EFFECT OF CBT ON LOCUS OF CONTROL, EMOTIONAL INTELLIGENCE, AND PERCEIVED SOCIAL SUPPORT IN PATIENT WITH SUBSTANCE USE (ALCOHOL)

A DISSERTATION SUBMITTED TO

BABA FARID UNIVERSITY OF HEALTH SCIENCES, FARIDKOT (PUNJAB)

IN THE PARTIAL FULFILLMENT

FOR THE AWARD OF DEGREE OF

M. PHIL

IN

CLINICAL PSYCHOLOGY

2024

Submitted By

DEEPIKA SAINI

DEPARTMENT OF CLINICAL PSYCHOLOGY
DAYANAND MEDICAL COLLEGE AND HOSPITAL
LUDHIANA, PUNJAB

DECLARATION BY THE CANDIDATE

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_____

DEEPIKA SAINI
Department of Clinical Psychology,
Dayanand Medical College & Hospital,
Ludhiana, Punjab

Date:

Place:

CERTIFICATE OF SUPERVISORS

This is to certify that the work incorporated in this dissertation entitled "**EFFECT OF CBT ON LOCUS OF CONTROL, EMOTIONAL INTELLIGENCE, AND PERCEIVED SOCIAL SUPPORT IN PATIENT WITH SUBSTANCE USE (ALCOHOL)"** has been carried out by **Deepika Saini** under our direct supervision. The data incorporated in this thesis is original and genuine and has been carried out by the candidate herself.

Signature of Supervisor

Dr. Bholeshwar Prasad Mishra
Professor & Head
Department of Clinical Psychology
DMC&H, Ludhiana

Signature of Co-Supervisors

Palak Upadhyay
Assistant & Head
Department of Clinical Psychology
DMC&H, Ludhiana

Dr. Pankaj Kumar
Professor
Department of Psychiatry
DMC&H, Ludhiana

Date:

ENDORSEMENT BY THE HEAD OF THE INSTITUTE

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Deepika Saini
Department of Clinical Psychology,
Dayanand Medical College & Hospital,
Ludhiana, Punjab - 141001

Date:

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Dedicated

to

my Family

&

Teachers

ACKNOWLEDGEMENT

It has been a long journey and it wouldn't have been accomplished without the love and support of a lot of well-wishers. I am grateful for the constant help and guidance of my supervisor **Dr. B.P Mishra**, professor and head of the Department of Clinical Psychology, DMCH. He has always inspired me with his passion for the field of clinical psychology and mental health his approachability as a professor has helped me clarify my innumerable queries without hesitation I am forever indebted to him. His professional conduct and scholarly competence have always motivated me to work on myself to be a better professional and a better human being. His anecdotes throughout these two years will always stay with me. Co-supervisor **Palak Upadhyay**, assistant professor, department of clinical psychology, dmch. She was always there to encourage me and enlighten me throughout these two years. Her valuable insights have helped me tremendously to polish my professional rectitude. I have gained invaluable insights into the intricacies of my field, honed my research skills, and developed a deeper understanding of complex concepts. Co-supervisor **Ms. Gursabeen Kaur**, assistant professor, Department of Clinical Psychology I extend my heartfelt gratitude to my supervisor whose unwavering support, expertise, and mentorship have been indispensable throughout this research endeavor. Their insightful guidance, constructive feedback, and encouragement have not only shaped the direction of this study but also fostered my intellectual growth and development as a researcher. I am immensely grateful for their dedication, patience, and belief in my abilities, which have been instrumental in overcoming challenges and achieving milestones.

I humbly thank my co-supervisor **Dr Pankaj Kumar sir**, professor, department of Psychiatry, DMCH for his valuable suggestions and scholarly guidance throughout this journey. Thank you to all the patients who agreed to be a part of this study. Thank you to all the staff members of the Department of Clinical Psychology and the Department of Psychiatry who eased my way through this degree and dissertation

gracious thanks to Dr. Prince from the R&D department, DMCH for helping me thoroughly with the analysis and formatting of this dissertation is my great pleasure to thank those without whose support this thesis would have been an impossible task to complete.

I would like to express my deepest gratitude to remarkable women who have been pillars of strength and support throughout my journey: **my mother Parminder Saini, my sister Sumiti Saini, my mother-in-law Beant Kaur and my aunties Mrs. Rajni Priya and Mrs. Davinder Saini.** Their unwavering love, guidance, and encouragement have played an indispensable role in shaping both my personal and professional life, and I am profoundly grateful for their presence in my life.

First and foremost, I extend my heartfelt thanks to my mother, whose boundless love and sacrifices have been the cornerstone of my existence. From instilling in me the values of kindness and resilience to nurturing my dreams with unwavering belief, her unwavering support has been my guiding light through every triumph and tribulation. Her wisdom, grace, and unwavering support have been my guiding light, and I am forever indebted to her for her immeasurable contributions to my life.

I am equally grateful to my sister, whose unwavering support and camaraderie have been a source of solace and inspiration. Her unwavering belief in my abilities, coupled with her endless encouragement, have propelled me to strive for excellence and pursue my passions with unwavering determination. Whether celebrating my successes or offering a shoulder to lean on during challenging times, her presence has been a source of strength and comfort, and I am deeply appreciative of her unwavering support.

To my wonderful aunties, your support has been a source of strength and comfort, guiding me through life's ups and downs. Your kindness and wisdom have been a beacon of light in my darkest moments, and your love has filled my heart with joy. I am immensely grateful for your unwavering presence and the invaluable role you've played in shaping who I am today. Thank you for everything.

I extend my heartfelt gratitude to my mother-in-law Mrs. Beant Kaur, whose boundless love, warmth, and wisdom have enriched my life in countless ways. Her unconditional acceptance and support have made me feel like a cherished member of the family from the very beginning, and I am profoundly grateful for her generosity of spirit and kindness. Her invaluable guidance and sage advice have been a source of wisdom and inspiration, and I am truly blessed to have her as a guiding presence in my life.

I would also like to extend my appreciation to my entire family for their unwavering support and encouragement throughout this journey. Their love, understanding, and encouragement have been a source of strength and motivation, and I am deeply grateful for their presence in my life.

Thank you, my loving husband Mr. Gurpinder Singh Malhi, for always being my rock of support even on days when I fail to reciprocate. Whose unconditional love, support, and understanding have been a source of strength and inspiration, I extend heartfelt gratitude. Your unwavering belief in my potential, sacrifices made on my behalf, and encouragement during challenging times have been the cornerstone of my success. I am deeply grateful for your love, encouragement, and unwavering support, which have empowered me to pursue my academic and professional aspirations with confidence and determination. I am more than grateful to have you by my side.

Huge thank you to my father-in-law **Mr.Manmohan Singh Malhi** for always supporting me in ways that you might not even know of. I am deeply grateful for the love, care, and support you have given me throughout my M.Phil degree. Thank you for always making me feel that I belong, thank you for always making me feel at home.

My loving and supportive **senior** huge thank you to you for teaching me throughout my degree and supporting my dissertation

I would like to thank my brilliant colleagues **Meitrai, Sadiya, Somya, and Mudita** who sailed through with me on this rocky boat. Who have provided invaluable support, encouragement, and camaraderie throughout this research journey. Their insights, perspectives, and

encouragement have enriched my understanding of the subject matter and inspired me to overcome obstacles with resilience and determination. I am deeply appreciative of their friendship, support, and collaborative spirit, which have made this journey all the more rewarding and fulfilling. I have learned so much from you in these two years that I can't explain. Thank you for sailing through with me on this rocky boat.

Huge thank you to my juniors **Trisha, Darpan, Apoorva, Surmeet, and Harleen**, whose enthusiasm, energy, and fresh perspectives have brought vibrancy and excitement to our academic community. Your curiosity, creativity, and eagerness to learn have invigorated our shared academic journey, inspiring us to push the boundaries of knowledge and explore new frontiers in research. Thank you to this beautiful city of Ludhiana for giving me everything I couldn't have imagined. You have been magical and I am so glad I could be a part of you. And at last, I would like to thank myself. Thank you to me for not giving up, for doing all this hard work personally and professionally, and for striving to be better than my yesterday self every day.

Deepika Saini

ABBREVIATIONS

-AUD: Alcohol Use Disorder

- CBT: Cognitive Behaviour Therapy

- E-LOC: External Locus of Control

- EI: Emotional Intelligence

- EII: Emotional Intelligence Inventory

- EQ: Emotional Quotient

- I-LOC: Internal Locus of Control

- LOC: Locus of Control

- MSPSS: Multidimensional Scale of Perceived Social Support

- -VE: Negative

- PSS: Perceived Social Support

- SUB: Substance Use Disorder

-SES: Socioeconomic status

ABSTRACT

Introduction: This study explores how CBT influences the relationship b/w LOC, EI, and PSS in those with substance use disorder. CBT, renowned for its efficacy in treating substance use, addresses emotional management and coping skills. By examining changes in LOC, EI, and PSS, the study aims to gauge the effectiveness of CBT in enhancing these factors among individuals undergoing substance use treatment.

Aim of Study: 1)To study the pre-post effect of CBT on LOC in patients with substance use disorder(alcohol). (2)To study the pre-post effect of CBT on EI in patients with substance use disorder (alcohol). (3)To study the pre-post effect of CBT On P.S.S in a patient with substance use disorder(alcohol).

Materials & methods: The study will be conducted on 40 patients diagnosed with AUD, admitted to the psychiatry ward or visiting psychiatry OPD & IPD. evaluation will be done pre and post-CBT intervention using Rotter's LOC, MSPSS, and EII pre and post-intervention. 8 CBT sessions will be delivered via individual therapy. 21version SPSS was used to analyze the data.

Results: The study focused on individuals with AUD who underwent 8 sessions of CBT. Pre-& post-intervention assessments were conducted on various metrics, including LOC, EI, & PSS. Post-intervention results demonstrated significant enhancements in EI & PSS, with positive correlations b/w pre-& post-scores. However, no notable change was observed in LOC between post-intervention & follow-up. Nonetheless, moderate to strong positive associations were found between post & follow-up scores for EI & PSS, while LOC exhibited weaker correlations. These findings underscore CBT's potential efficacy in improving psychosocial aspects related to alcohol misuse among SUD patients.

Conclusion: The study underscores CBT's efficacy in enhancing EI and PSS among individuals with AUD. Although notable improvements were observed post-intervention, LOC showed no significant change. Positive correlations between post-intervention and follow-up scores for EI and PSS suggest sustained benefits. These findings highlight the necessity for tailored interventions in AUD treatment, urging further investigation for long-term therapeutic success.

Keywords: Substance use, alcohol use disorder, Locus Of Control, Emotional Intelligence, Perceived Social Support, cognitive behavioral therapy. Therapy, therapy intervention.

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KEY TO MASTER CHART

PRE EII – pre-intervention emotional intelligence inventory.

PRE EII GRADE - pre-intervention emotional intelligence inventory grade.

PRE-PSS - pre-intervention perceived social support.

PRE-PSS RAW SCORE - pre-intervention perceived social support. Raw score.

PRE-PSS GRADE CATEGORY - pre-intervention perceived social support grade category.

PRE-LOC – the pre-intervention locus of control.

PRE-LOC GRADE - the pre-intervention locus of control grade.

POST EII – post-intervention emotional intelligence inventory.

POST EII GRADE – post-intervention emotional intelligence inventory grade.

POST-PSS - post-intervention perceived social support.

POST-PSS RAW SCORE - post-intervention perceived social support. Raw score.

POST PSS GRADE CATEGORY - post-intervention perceived social support grade category.

POST-LOC – post-intervention locus of control.

POST-LOC GRADE - the post-intervention locus of control grade.

FOLLOW-UP EII – follow-up intervention emotional intelligence inventory.

FOLLOW-UP EII GRADE – follow-up intervention emotional intelligence inventory grade.

FOLLOW-UP -PSS - follow-up -intervention perceived social support.

FOLLOW-UP -PSS RAW SCORE - follow-up -intervention perceived social support. Raw score.

FOLLOW-UP PSS GRADE CATEGORY - follow-up intervention perceived social support grade category.

FOLLOW-UP -LOC – follow-up -intervention locus of control.

FOLLOW-UP -LOC GRADE - follow-up- intervention locus of control Grade.

BABA FARID UNIVERSITY OF HEALTH SCIENCES
Sadiq Road, Faridkot-151203 (Pb.) INDIA
Phone No. 91-1639-256253 and Fax No. 91-1639-256234
Website: www.bfuhs.ac.in, Email: bfuhspc@gmail.com
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Supervisor: **Dr. Bholeshwar Prasad Mishra**

Co-Supervisor: **Dr. Pankaj Kumar & Dr. Palak Upadhyay**

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INTRODUCTION

Substance abuse disorder is a grave condition characterized by heavy drug use. When drug use interferes with one's capacity to go about their daily lives it happens.

Drugs, with or without a prescription, may cause it. Substance use disorders were formerly referred to as "drug abuse" by medical practitioners. Addiction is another name for substance use disorder.

The American Psychiatric Association (APA)[1] describes substance use disorder as an illness of the brain. It is typified by recurrent drug use despite side effects. Substance use disorders are caused by a multitude of biological and social factors. A simple definition of drug usage is any detrimental pattern of using any substance to change one's mood. Alcohol and other drugs, whether legal or not, as well as certain chemicals that aren't even drugs, can all be considered "substances". When you use a substance in a way that is not intended or advised, or when you use more than is prescribed, "abuse" may ensue. To be clear, it is possible to use drugs without developing an addiction or even a substance use disorder.

According to the Fifth Edition of the Diagnostic and Statistical Manual (DSM-5).[2] Addiction and substance abuse can afflict anyone. Addiction is mostly inherited, as is the case with many other illnesses. According to research, 40–60% of a person's vulnerability to having a substance use disorder may be attributed to hereditary factors. Substance addiction contributes to public health issues like driving while intoxicated, aggression, stress in the family, and the possibility of child abuse and neglect. The danger of contracting and spreading infectious diseases like HIV and hepatitis increases when intravenous drug users share or reuse needles.

Physical, sexual, or emotional abuse; exposure to trauma; and mental health conditions such as depression, anxiety, eating disorders, and personality disorders are additional risk factors for developing substance usage concerns.

CURRENT STUDY TARGETING PATIENTS WITH ALCOHOL USE DISORDER

ALCOHOL ' Alcohol ' refers to ' ethyl alcohol. ' In diluted concentrations of absolute (i.e., 100 percent) ethyl alcohol, it is consumed as an alcoholic beverage. One standard alcoholic beverage equals 10 g of absolute alcohol. The amount varies based on the kind of alcohol being consumed. Beer, wine, whiskey, rum, vodka, gin, brandy, etc are among the most commonly consumed alcoholic beverages.

According to recent figures, India is among the world's top manufacturers of alcohol, and over the past 15 years, the country has steadily increased its output. With 65% of the region's total output, India is the largest producer of alcoholic beverages in Southeast Asia, accounting for 7% of all imports. According to data from the Alcohol Atlas of India, India accounts for more than two-thirds of the region's total beverage alcohol consumption. From 887.2 million liters in 1992–1993 to 1,654 million liters in 1999–2000, production doubled. By 2007–08, it was predicted to triple to 2,300 million liters. **(Indian Alcohol Policy Alliance (IAPA), 2009**).[3]

PREVALENCE: According to the WHO, the total per capita drinking alcohol by people over 15 years old is 6.2 L of pure alcohol per year, which equates to 13.5 g of alcohol only per day. Alcohol consumption is responsible for nearly 5.1 percent of the global disease burden, and it kills nearly 3.3 million people each year.[4]

Over India, the 12-month the frequency of alcohol-related disorders was 2.6 percent in 2010, and Alcoholism was 2.1 percent. In 2012, drunk driving was responsible for 33.1 percent of all traffic fatalities. As stated by the National Mental Health Survey of India 2015-16, The frequency of AUDs in adult men is 9 %. The alcohol-attributable fraction (AAF) of all-cause deaths in India was found to be 5.4 percent. Alcohol use was responsible for approximately 62.9 percent of all deaths due to liver cirrhosis.[5]

In 2019 a survey was conducted recently on consumption of substances in India. The Social Justice and Empowerment Ministry was surveyed *by the All-India Institute of Medical Sciences (AIIMS)*.[6] *The survey* covered the general population (10-75 years), in all 36 states and union territories covering over 2 lakh households and 4.73 lakh people in 186 districts of the country. India is home to six crore alcohol addicts, 5.2 % of Indians more than 5.7 crore people are estimated to be affected by harmful or dependent alcohol use. More than 3.1 crore Indians (2.8%) have reported using cannabis products, Bhang, Ganja, Charas, Heroin, and Opium, in the last year. Only one in every 20 drug users receives treatment at a hospital. Country liquor accounts for 30% of the total liquor consumption, and Indian-made foreign liquor also accounts for the same amount. The prevalence of cannabis use disorders is about three times higher in Punjab and Sikkim than it is in the country as a whole.

At the national level, Heroin is the most widely utilized substance followed by pharmaceutical opioids, followed by opium (Afeem). Less than 1% or nearly 1.18 crore people use sedatives, non-medical or non-prescription use.

Alcohol use is a significant issue for public health in Punjab. The present study reports an estimate of the prevalence of substance use disorders in Punjab, conducted as part of the National Mental Health Survey (2019),[7] India. 2895 individuals from 719 households of 60 clusters (from 4 districts of Punjab) were interviewed. Alcohol and other illnesses related to substance abuse had weighted prevalence rates of 7.9 and 2.48 percent, respectively.

The prevalence of tobacco dependence was 5.5 percent; 35 percent of households had one person with SUD. The prevalence was greatest in the productive age group (30-39 years), The prevalence of alcohol along with other SUD was much higher in Punjab in contrast to other States where the survey was done. Tobacco dependence was lowest in Punjab. The majority (87%) of the persons with SUD did not suffer from any other mental disorder.

THE EFFECTS OF ALCOHOL

Genetic Aspects Regarding Alcoholism Generally, investigations of those who were adopted, twins, and families affected by the disorder are the first steps in the quest for genetic factors in any complicated disorder. These studies can serve as the basis for further research and offer early information regarding the likely significance of genetic variables. While the findings of these studies are not in agreement, when considered collectively, they offer strong support for the role that genetics plays in this condition and show that between 40% and 60% of the variation in alcoholism's heritability can be ascribed to genetic factors.

(**Dick and Foroud, 2003**)[8]

Family Studies Relatives of alcoholics have significantly greater rates of alcoholism than relatives of non-alcoholics, according to numerous studies, with children of alcoholics showing a 4-5-fold increased chance of getting the illness. (Enoch and Goldman, 2002).[9] Given that most family studies indicate that relatives of alcoholic probands have a higher incidence of the condition, this elevated risk seems to be rather specific to alcoholism.

(Schuckit, 1987).[10] Even though family studies offer some preliminary They are not definitive in and of themselves, although alcoholism may run in families. The common social and developmental influences of growing up in the same surroundings under the same biological parents may also be reflected in familial aggregation.

Twin Studies Research involving twins compares the similarity or concordance rates for illness in pairs of monozygotic twins with those of dizygotic twins to assess the relative contributions of genetic and environmental factors. Researchers can calculate the proportional roles that environmental and genetic factors play in determining a person's likelihood of developing alcoholism and other SUD with the twin research design.

Generally speaking, twin research identifies three components of the liability: Three main environmental impacts are known to affect twins: (a) additive genetic effects; (b) common environmental effects (like parental upbringing and the intrauterine environment); and (c) particular, non-shared environmental experiences (Prescott and Kendler, 1995).[11] Compared to fraternal twin pairs, which, like regular siblings, typically share only half of their genes, identical twin pairs that share all of their DNA should have higher concordance rates for gene-transmitted illnesses. However, if both varieties of twins were exposed to diseases brought on by the environment shouldn't be able to discriminate between monozygotic and dizygotic twin pairs if they shared the same early environment. Several important twin studies have examined the concordance rates for alcoholism between identical and fraternal twins.

Kaij (1960) discovered that the concordance rate for alcoholism in male monozygotic pairs was higher (about 60% vs. 39%) than it was for dizygotic twins. Remarkably, in these male twin pairs, the difference in concordance rates grew in direct proportion to the degree of drinking, supporting a hereditary diathesis. For identical male twin pairs, a similar greater concordance rate was seen in a Veterans Administration twin register research.

(McGue et al., 1992).[12] Results in women were originally less consistent than those in male-male twin pairs, which repeatedly showed that genetic variables had a significant role in the genesis of alcoholism in men. Consequently, several smaller twin investigations discovered little to nothing.

(Pickens et al., 1991).[13] genetic impact on women as opposed to men. On the other hand, in a sizable sample of identical twin girls

, Twin studies on alcoholism compare the risk between identical (MZ) twins, who share all genes, and fraternal (DZ) twins, who share about half. Higher alcoholism rates in both pairs of twins than in the general population suggest genetic and environmental factors play a role. If genetics are key, MZ twins should show a significantly higher risk ratio than DZ twins. Andrew C Heath, (1995).[14] Thus, the vast

majority of twin studies support the notion that alcoholism is genetically influenced and that heritable factors are important in the vulnerability of the disorder in both men and women.

Adoption Studies Examining individuals who were raised by non-relative adoptive parents after being separated from their biological relatives shortly after birth is possibly the most persuasive method to distinguish genetic influences from environmental ones.
(Goodwin, 1983).[15] A half-sibling strategy or traditional adoption research can be used for this. Numerous adoption and half-sibling studies have assessed the likelihood that drinking has genetic roots. About the half-sibling strategy, Schuckit and associates (1972)[16] examined a group of people who had grown up without their biological parents but had an alcoholic biological parent or surrogate. Individuals who experienced severe alcohol issues from their biological parents were far more likely to become alcoholics themselves than those whose surrogate parents also struggled with alcoholism.
(Goodwin 1979) [17] found that the probability of the sons becoming alcoholics increased by approximately four times when they grew up with either of their drinking parents. Neither biological parents nor non-alcoholic adoptive parents reduced this elevated risk. (Cloninger 1981)[18] revealed that adopted-out sons of biological fathers who were identified as having alcohol problems had far higher rates of alcohol misuse.

DIAGNOSTIC CRITERIA (ICD-10, WHO, 2007) FOR ACUTE ALCOHOL INTOXICATION[19]

A. The criteria for acute intoxication (F1x.0)

1. Extensive proof of recent intoxication-consistent usage of a psychoactive substance (or substances) at high enough dose levels.
2. Symptoms or signs of intoxication compatible with the known actions of the particular substance (or substances), as specified below, and of sufficient severity to produce disturbances in the level of

consciousness, cognition, perception, affect, or behavior of clinical importance.

3. Not accounted for by a medical disorder unrelated to substance use, and not better accounted for by another mental or behavioral disorder.

B. Dysfunctional behavior, evident by at least one of the following:

1. disinhibition;
2. argumentativeness;
3. aggression;
4. lability of mood;
5. impaired attention;
6. impaired judgement;
7. interference with personal functioning.

C. At least one of the following signs:

1. unsteady gait;
2. difficulty standing;
3. slurred speech;
4. nystagmus;
5. decreased level of consciousness (e.g. stupor, coma);
6. flushed face,
7. conjunctival injection.

DIAGNOSTIC CRITERIA FOR PATHOLOGICAL ALCOHOL INTOXICATION (ICD-10, WHO, 2007)[20] The status of this condition is being examined. These research criteria must be regarded as tentative.

A. The general criteria for acute intoxication (F1x.0) are met, with the exception that pathological intoxication occurs after drinking amounts of alcohol which are not sufficient to cause intoxication in most people.

B. Verbally aggressive or physically violent behavior that is not typical of the person when sober.

C. Occurs very soon (usually a few minutes) after consumption of alcohol.

D. No evidence of organic cerebral disorder or other mental disorders.

ALCOHOL USE DISORDER- DIAGNOSTIC CRITERIA AS PER DSM - 5 [21]**;**

A. A problematic pattern of alcohol use results in clinically significant impairment or distress, as is manifested by at least two of the following over 12 months:

1. Alcohol is frequently consumed in greater quantities or over a longer period than intended.

2. There is a persistent desire or unsuccessful attempt to reduce or control alcohol use.

3. A significant amount of time is spent on activities that are required to obtain alcohol, use alcohol, or recover from its effects.

4. Craving, or a strong desire or urge to consume alcohol.

5. Recurrent alcohol use that fails to meet major role obligations at work, school, or home.

6. Continued alcohol use despite persistent or recurring social or interpersonal problems caused or exacerbated by alcohol's effects.

7. Significant social, occupational, or recreational activities are discontinued or reduced as a result of alcohol use.

8. Recurring use of alcohol in physically hazardous situations.

9. Continued alcohol use despite knowledge of a persistent or recurring physical or psychological problem that is likely to have been caused or exacerbated by alcohol.

10. Tolerance, as defined by one of the following :

a. The requirement for the markedly increased amounts of alcohol to achieve intoxication or the desired effect.

b . A significantly diminished effect with continued use of the same amount of alcohol.

11. Withdrawal manifested by any one of the following:

a. The characteristic withdrawal syndrome for alcohol.

b. Alcohol (or a closely related substance, like benzodiazepine) is used to relieve or prevent withdrawal symptoms.

ADDICTION CYCLE, STAGES, RELAPSE AND RECOVERY

Gorski& Miller (1986)[22] described the addiction cycle in six steps i.e.

1. Short-term (Temporary) gratification

2. Long-term pain and Dysfunction

3. Addictive rational (thinking)

4. Increased acceptance (tolerance)

5. Control loss (losing control)

6. Bio-psycho-social damage

1. **Short-Term Gratification**: First there is short-term gratification. You feel good now.

2. **Long-term Pain and Dysfunction**: The short-term gratification is eventually followed by long-term pain. Using addictive chemicals or chemicals directly causes this agony, some of which is from physical withdrawal and some of which is from the incapacity to manage psycho-socially without drugs or alcohol.

3. Addictive Thinking: Addictive thinking is brought on by chronic pain and dysfunction. Obsession and compulsion are the foundations of addictive thought.

4. Increased Tolerance: The drug needs to be taken in greater and greater amounts to have the same effect without you realizing it.

5. Loss of Control: The obsession and compulsion become so strong that you cannot think about anything else. Your feelings and emotions become distorted by the compulsion. You become stressed and uncomfortable until finally, the urge to use is so strong that you cannot resist it. Once you use addictive chemicals or addictive behaviors again, the cycle starts all over.

6. **Bio-Psycho-Social Damage:** Over time, there might be harm to your mental and physical well-being, as well as your social and psychological connections with others. As pain and stress get worse, the compulsion to use addictive drugs or behaviors to get relief from the pain increases. A deadly trap develops. You need addictive use to feel good. When you use addictively you damage yourself physically, psychologically, and socially. The damage increases one's pain which increases our need for addictive use.

THEORIES RELATED TO ALCOHOL USE DISORDER[25]

Physiological theories related to Alcoholism

1. Theory of heredity**:** Family studies consistently show a significant genetic component in alcohol dependence. While progress has been made in identifying genes linked to susceptibility, research has been limited by small sample sizes. Larger consortia are forming for meta-analyses, which are expected to yield more robust associations. Exploring pathways or gene sets is another promising approach. In the coming years, we anticipate further discoveries of both common and rare genetic variants influencing alcohol dependence risk.[23]

2. Endocrine theory: Alcohol affects the hypothalamic–pituitary–adrenal (HPA) axis and stress response by stimulating neurons in the hypothalamus to release corticotropin-releasing factor (CRF) and arginine vasopressin (AVP). This triggers the production of adrenocorticotropic hormone (ACTH) in the anterior pituitary, leading to the release of glucocorticoid hormones (cortisol) from the adrenal glands. High cortisol levels inhibit CRF and ACTH release through negative feedback. Additionally, β-endorphin (BEP) from the hypothalamus regulates CRF release and inhibits the sympathetic nervous system's stress response. Alcohol exposure can stimulate the HPA-axis stress response acutely while inducing a blunted response chronically, characterized by an increase in proinflammatory cytokines and stress intolerance, contributing to immune dysfunction and alcohol use disorder.[24]

3. Psychodynamic Theories In classical Freudian psychoanalysis, addiction is attributed to an "oral fixation" resulting from traumatic experiences in childhood. Hooper (1995) suggests addiction stems from unconscious desires to fulfill fantasies and avoid responsibility, with specific drugs facilitating these fantasies. Chafetz (1959) described addiction as an "oral perversion," although later studies found no direct link between childhood oral overactivity and adult alcoholism. Addiction is viewed as aggressive behavior rooted in ego function defects by ego psychologists (Yalisove, 1997). Freud associated addiction with seeking immediate pleasure and escaping unhappiness, akin to finding completeness in collecting culturally significant objects like alcohol (Subkowski, 2006). According to

Abraham (1917), addiction and collecting represent repressed desires transferred to various objects. Psychoanalytical theory suggests addiction may stem from sublimation, redirecting sexual energy to external objects such as alcohol (Gurol, 2004). Dependency often arises from unresolved infantile trauma and faulty object relations, particularly with inconsistent maternal care (Gurol, 2004; Ramos, 2004). Dependency patterns may also relate to maternal figures' empathetic or lacking nature, influencing self-care capacity (Ramos, 2004). Studies show that alcoholic patients' mothers have similar rates of issues compared to other patient populations. At the same time, the absence of a father figure is linked to a fragile ego in alcoholics (Ramos, 2004). Overall, psychodynamic theories emphasize dysfunctional ego and problems in the desire for gratification.

4. Behavior theories: Behavioral theories of psychology focus on observable and measurable behavior. Skinner, a prominent figure in behavioral psychology, viewed addiction as a societal flaw resulting from inadequate reinforcement of functional behaviors (Thombs, 2006). Learning in behavioral psychology occurs through two types of conditioning: classical (respondent/Pavlovian) conditioning, where reflexive behaviors change by pairing stimuli, and operant conditioning, where behaviors are reinforced or punished based on consequences. For instance, the environment may serve as a conditioned stimulus for the positive effects of alcohol, leading the dependent individual to associate certain settings with socialization or euphoria. The person becomes accustomed to drinking and may struggle to socialize without alcohol, leading to impaired social skills. Operant conditioning, proposed by Skinner, involves voluntary behaviors learned through reinforcement or punishment (Thombs, 2006). Positive consequences of drinking, like euphoria or increased sociability, act as positive reinforcements, while relief from withdrawal symptoms serves as negative reinforcement. Detoxification can reduce tolerance, leading to alcohol intoxication upon resuming drinking. Negative events following alcohol intake, such as intoxication or illness, act as punishments,

decreasing the likelihood of further drinking. Relapse can occur due to the removal of reinforcement or extinction of the behavior.

5. Cognitive theories: Cognitive models explore the relationship between emotional states and thoughts, including expectancies, beliefs, schemas, automatic thoughts, and thinking errors. Bandura's social learning theory, also known as social cognitive theory or self-efficacy theory, is influential in this field, alongside explanations of addiction by Goldman, Brown, and Christiansen. Social cognitive theorists challenge the notion that thoughts and desires are uncontrollable, proposing that individuals can learn behaviors through observation, known as vicarious learning. According to Bandura, vicarious learning, or modeling, occurs in three ways: observational learning effects, inhibitory-disinhibitory effects, and facilitation effects (Thombs, 2006). Bandura (1986) defines self-efficacy as the belief in one's ability to successfully execute behaviors to achieve desired outcomes. High self-efficacy leads individuals to view challenges as surmountable rather than insurmountable obstacles to happiness. Successful quitters in addiction and eating disorders often exhibit high self-efficacy. In addition, self-efficacy becomes crucial after overcoming physical dependence, as psychological urges can induce relapse. Bandura identifies four sources of self-efficacy achievements in performance, secondary experiences, verbal

persuasion, and emotional arousal. Participant modeling, observing successful behaviors, verbal encouragement, and managing emotional arousal are effective strategies to enhance self-efficacy. Bandura's study on snake phobia patients demonstrated that higher self-efficacy predicts successful treatment outcomes. Recently, self-efficacy has been integrated into addiction models, showing its relevance to stages of change (Prochaska & Norcross, 2003).

6. The Trans-theoretical Model of Change (TTM): Prochaska and Norcross (2003) critique existing psychotherapy theories for lacking empirical support and focusing more on problem behaviors than change processes. They argue that eclectic approaches also lack empirical basis. To address these issues, they propose the trans-

theoretical model of change, which includes three core dimensions: Processes, Stages, and Levels of change. Psychological theories linking psychological factors to alcoholism face challenges, as differences between alcoholics and controls may result from years of drinking rather than causal factors.

7. Self-Regulatory deficiencies One major conceptual framework for comprehending Alcohol abuse highlights weaknesses in self-regulation, including deficiencies in self-care, self-development and affects, links between self and object, and self-esteem. The ego must act as a warning system and a guide to keep the self safe from actual exterior threats as well as from internal emotional instability and disorder.

(Khantzian et.al.,1981). It follows that many drug abusers have difficult and perplexing feelings, problematic behaviors, low self-esteem, turbulent relationships, or lonely lives as a result of their deficiencies in self-regulation.

Wilson (1989used the hierarchic (multifaceted) epigenetic theory of self-organization first put forth by Gedo (1986) to develop a hierarchic model of opiate addiction based on failures in self-regulation. Assessing verbal and nonverbal self-regulation deficits in addicts using the Scale for deficits in Self-Regulation,

According to the study, addicts struggle with self-regulation much more than healthy participants do.

8. VULNERABILITIES ABOUT ONE'S SELF-DEVELOPMENT AS WELL SELF-ESTEEM

According to Wurmser (1974), obsessive drug users attempt to reestablish an almighty position in which they are either grandiose and limitless or the other person, the archaic self-object, is viewed as all-giving and held to the highest standards. The unpleasant effects of fury, embarrassment, and abandonment are felt when restrictions are placed. When the perfect world or the ideal self crumbles, rage follows. Disparities between the grandiose, ideal self and the constrained, disappointing self give rise to feelings of shame. When the self-objects

do not provide as much as anticipated, the abandonment feelings become quite damaging. The ability of drugs to lessen or even completely eradicate these three fundamental effects makes them significant.

Addicts of drugs fail to grow up with a healthy sense of self-worth and affection for themselves. They struggle to feel important in the world and lack confidence in their skills and abilities (Khantzian et.al, 1990).

alcohol has an interaction with the painful defenses and feelings of inadequacy that people experience, temporarily relieving their agony or improving their self-esteem.

9. complex self-object relationships Alcohol abusers may have significant relationship issues due to deficiencies in their self-development and self-esteem (Khantzian et.al, 1995). Even though they desperately want other people to understand them, they frequently act in a way that is counter-dependent, deny their needs, and fear and despise their dependence. They frequently take things too far, isolating themselves or being completely dependent on and obedient to others.

ALCOHOLISM-RELATED SOCIOLOGICAL THEORIES [26]

Within and across societies, cultures, subcultures, and ethnic and religious groupings, alcohol has a wide range of purposes. Views on its utilization range from total non-existence to extreme permissiveness. However, there are always some who abstain when permissiveness is the watchword, and drinking does not go away when abstinence is abandoned. Alcohol is utilized for ceremonial, hedonistic, religious, gastronomic, psychological, traditional, social, and medical purposes. The accepted level of behavior when it comes to drinking differs depending on factors including age, occasion, sex, social class, cultural background, and unique situations.

1. Cultural theory According to the cultural theory of alcoholism, there are three ways that a society's culture might affect the prevalence of alcoholism. The degree to which the culture functions to start either conflicts or urgent needs for changes in its members' behavior; b) The attitudes regarding drinking that the culture instills in its members. c)

The extent to which the culture offers acceptable alternatives for achieving fulfillment.

2. The **hypothesis of deviant conduct** Alcohol usage can be prohibited or detested, legal or just illicit, acceptable, perhaps even holy, or both, depending on the circumstances. Thus, academics are paying more and more attention to the idea that alcohol misuse is an aberrant behavior. According to the deviant behavior idea, alcoholics are people who, due to a variety of situations, become publicly labeled a deviant and are forced by society's reaction into playing a deviant role

3. Tension reduction Hypothesis. Alcohol's potential to ease tensions has been the focus of several research. There are two components to the alleged impact of alcohol on tension that may be connected to alcoholism:

The initial section presents the concept that individuals with alcohol addiction may have varying baseline levels of anxiety in comparison to non-alcoholics. The subsequent section discusses the potential impact of alcohol on the varied reduction of tension levels among alcohol users (Roebuck & Kessler,1972). Stressful life events are reported to cause alcohol-related problems in alcoholics (Morriserry&Schuckit,1978). The theory also stresses that alcohol helps them to relax after a stressful day though very little data support a direct cause-effect relationship between specific stressors and the onset of alcoholism. Thus, when it comes to describing the origin of alcoholism, the tension reduction hypothesis is still a tentative notion. (Cappel& Herman, 1972).

4. Reinforcement theories. The idea behind reinforcement theories is that when people start drinking, they eventually drink too much., or remain alcoholic because alcohol serves some useful purpose; that is, there is reinforcement or reward for the drinking activity.

A rewarding experience could involve the induction of enjoyable psychological change, and the removal of discomfort (Conger,1956or engaging in other joyful activities has been suggested that drinking

alcohol is a taught behavior brought on by children's need to see or mimic adult conduct.

Among purported positive reinforcing properties are approval of peers, enhanced or altered social interactions (Nathan &Lisman, 1976), decreasing the pressure of a hard day, and offering the chance to feel independent or powerful (Roebuck, 1972).

5. Transactional theories. Transactional theories assume that disordered levels of communication may have been responsible for both the initial development of alcohol intake and alcoholism and that these levels of communication become rather more disordered and self-perpetuating as alcohol intake increases (Steiner, 1971). Steiner also stated that the consequences of being drunk become a game in itself and might become self-reinforcing. This idea states that alcoholism is a way of interacting where the person and his family utilize inebriation and helplessness as justifications for actions. As a consequence, one unexpected result can be the disintegration of the family interaction when the alcoholic stops drinking; new rules have to be established for the family to survive as a unit (Ward & Faillace, 1970).

6. Personality theories The consensus of personality studies is that no one personality type can be measured as being necessary and sufficient for how alcoholism develops and the range of personality types of alcoholics is not different from that found in the general.

7. Excuse Theory When people drink, they attribute Most of their behaviors that have the effect of drinking, especially if they might otherwise be blamed or criticized for misconduct while drinking. Being under the impact of some drugs like alcohol is widely accepted by others as a social excuse (MacAndrew & Edgerton, 1969).

8. Socio-Cultural Theories Alcoholism is connected to socio-cultural factors. Super/supracultural alcoholism is thought to arise in any civilization when The lack of indulgence in children is combined with severe views about success and a constrictive stance toward adults' dependent behavior (Becon et al., 1974). Other culture-specific Alcoholism is viewed by subcultural theories as the outcome of

declining social mobility, perhaps starting earlier than the issue of drinking (Jones &Borland, 1975). This can result from an inability of individuals to Engage in community events; failure to do so may lead to frustration and the development of alcohol-related disorder.

Once alcoholism has begun, cultural factors may help to determine the most prevalent type of problem drinking (Ward & Faillace, 1970). It was also found that alcoholism often correlates with the degree of cultural stress (Jones &Borland, 1975). The concordance between alcoholism and crime, between alcohol abuse and forms of psychiatric illness has led to the primary-versus-secondary alcoholism dichotomy and theories on the significance of personality in alcoholism. Family history and twin study information from the population have resulted in a genetic hypothesis. No one cause for alcoholism is known. This is at least in part, a result of the length of time between the onset of drinking and the development of alcoholism as well as that several different factors may be involved at the same time. The theories are not mutually exclusive and are somewhat arbitrarily divided into psychological theories, socio-cultural theories, and constitutional theories (Roebuck & Kessler, 1972)The reasons for some people's alcohol abuse are complex and multifaceted. One of the central findings of the large collection of studies that have examined the psychosocial causes of alcohol use is that multiple pathways to behavior involve alcohol consumption (Sher et al., 1997). Alcohol misuse is caused by a variety of biological and psychosocial elements that are interdependent another; it is false to think of psychosocial causes as existing independently of or in competition with biological causes. It is preferable to think of alcohol consumption and alcoholism as the results of a confluence of biopsychosocial factors. Researchers face the challenge of explaining

LOCUS OF CONTROL (LOC); is the extent to which people think they influence how events in their lives turn out, as opposed to outside causes (beyond their control). Since its creation in 1954 Written by Julian B. Rotter, the idea has been incorporated into personality research. The Latin term "locus" (plural "loci" (meaning "place" or "location") denotes the belief in one's power over one's own life. It can

be external, meaning they think fate or chance controls their lives, or internal, meaning they think they can control their own lives. (Rotter, 1966).[27]

Herbert m. Lefcourt (1976) [28] defined the perceived LOC as "a broad expectation of internal rather than external control of reinforcements". Strong I-LOC individuals think that their actions are mostly responsible for the occurrences in their lives. For instance, when they receive exam results, these individuals often compliment or criticize their abilities. Individuals who have a strong E-LOC frequently extol or criticize outside forces like the instructor or the test.

A complex variable, LOC is used in a large portion of psychology research. Clinical psychology, health psychology, and educational psychology are among the domains in which the LOC construct is applicable. But when determining an individual's overall personality traits, LOC is important, especially when combined with related notions like self-efficacy and attribution style—a concept associated with explanations for past events.

In individuals struggling with AUD, the concept of LOC takes on particular significance, influencing their behaviors, attitudes, and treatment outcomes. Understanding the LOC in this population is essential for tailoring effective interventions and promoting recovery. This discussion will explore the components of LOC in alcoholics, considering both internal and external attributions, as well as their implications for treatment approaches.

1. Internal Locus of Control (I-LOC): I-LOC refers to the belief that one has control over their acts and the outcomes they experience. In the context of AUD, individuals with I-LOC may attribute their drinking behaviors, relapses, and recovery efforts to their own decisions, willpower, and efforts. They perceive themselves as active agents in their journey toward sobriety, believing that they have the power to make positive changes in their lives. Research suggests that individuals with a more I-LOC tend to exhibit greater motivation for

change and engage more actively in treatment interventions (Rotter, 1954; Skinner, 1996).[29]

2. External Locus of Control (E-LOC):

Conversely, E-LOC involves attributing outcomes to external forces, such as fate, luck, or other people's influence. Regarding the circumstances surrounding AUD, individuals with an E-LOC may perceive their drinking behaviors as being influenced by factors beyond their control, such as stress, social pressures, or genetic predispositions. They might feel rather powerless to resist the urge to drink and might view recovery as dependent on external interventions or circumstances. Studies have found that individuals with more E-LOC may be less motivated to change their drinking behaviors and more prone to relapse (Lefcourt, 2013; Nowicki & Duke, 1974).[30]

EMOTIONAL INTELLIGENCE(EI) In broad terms, researchers have a different viewpoint for Emotional Intelligence (EI). Researchers have been studying emotional intelligence for more than 100 years. In literature, various definitions of emotional intelligence are available. Dr. J Mayer talked about EI as the intellectual intersection of thoughts and emotions. A more formal definition was given by Mayer, Salovey & Caruso (2004).[31] The concept of EI has engendered many interests both in the amateur& scientific fields. Mayer, Salovey& Caruso (2004)[32] viewed EI as a member of practical, societal, and personal intelligence. It was called hot intelligence because these operate on hot perceptions. EI is one of the types of social intelligence. It contains the capability to see his or her or others' emotions and can differentiate amongst them. Emotional intelligence is now considered by many as being essential for successful living. ability to distinguish his or her feelings from those of others. EI also denotes encouraging himself or herself, and handling emotions well himself (Goleman, 1998).[33] Reuven Bar-Onis the prominent researcher of the EI presented the concept of emotion quotient

DEFINITION OF EMOTIONS Emotional intelligence encompasses the capacity to identify, comprehend, and manage one's own emotions, and to recognize and influence the emotions of others (Salovey &

Mayer, 1990).[34] Empathy, self-control, self-awareness, and social skills are some of its essential elements. People who possess high emotional intelligence is competent in identifying their emotions, managing stress, empathizing with others, and navigating social situations effectively (Goleman, 1995).[35]

Emotional Intelligence in Alcoholics:

In individuals with AUD, emotional intelligence can influence their drinking behaviors, coping strategies, and treatment outcomes. Research suggests that deficits in emotional intelligence may contribute to the development and maintenance of problematic drinking patterns (Martins et al., 2016).[36] For example, individuals with low emotional intelligence may struggle to regulate their emotions effectively, leading them to rely on alcohol as a maladaptive coping mechanism for managing stress, anxiety, or negative mood states (Ciarrochi et al., 2001).[37]

Components of Emotional Intelligence in Alcoholics:

1. Self-Awareness: Individuals with AUD may have limited awareness of their emotions, triggers for drinking, and the impact of their alcohol use on their lives. Low self-awareness can hinder their ability to recognize warning signs of relapse or seek help when needed (Wong & Law, 2002).[38]

2. Self-Regulation: Difficulty in regulating emotions and impulses is common among individuals with AUD. They may struggle to cope with stress, cravings, or withdrawal symptoms without turning to alcohol for relief. Enhancing self-regulation skills is essential for preventing relapse and promoting long-term sobriety (Nelis et al., 2011).[39]

3. Empathy: Empathy deficits are often observed in individuals with AUD, affecting their ability to understand and respond to the emotions of others. Addressing empathy deficits through therapy or social skills training can improve interpersonal relationships and social support networks, which are crucial for recovery (Davis, 2010).[40]

4. Social Skills: Impaired social skills, such as communication, conflict resolution, and assertiveness, may contribute to social isolation and difficulties in maintaining healthy relationships. Building social skills can

help individuals with AUD rebuild their support systems and cope with social pressures to drink (Klingemann et al., 2010).[41]

PERCEIVED SOCIAL SUPPORT

MEANING AND DEFINITION of Perceived Social Support has been defined in various ways (Schwarzer, Knoll, & Rieckmann, 2004).[42] It refers to the function and quality of social relationships, such as perceived availability of help, or support received. Social support occurs through an interactive process and can be related to altruism, a sense of obligation, and the perception of reciprocity (Schwarzer & Leppin, 1991).[43] It could be viewed as something that other people offer, as coping support, as a resource exchange, or even as a personality characteristic.

P.S.S in patients with alcohol use disorder: Perceived social support, a multidimensional construct, plays a crucial role in the lives of individuals with alcohol use disorder (AUD), influencing their coping mechanisms, treatment outcomes, and overall well-being. Understanding the components of P.S.S. in patients with AUD is essential for developing effective interventions and support systems tailored to their specific needs. This discussion will explore the key components of P.S.S in individuals with AUD, including emotional, instrumental, informational, and appraisal support, along with their implications for treatment and recovery.

Emotional Support:

Emotional support refers to expressions of empathy, care, love, and understanding from one's social network. It involves having someone to confide in during difficult times, receive encouragement from, and feel valued and accepted by (Lakey & Cohen, 2000).[44] For individuals with AUD, emotional support provides a sense of belongingness and reassurance, reducing feelings of loneliness, isolation, and despair commonly experienced in addiction (Tracy & Johnson, 2007).[45] Having supportive individuals who offer comfort and validation can significantly impact patients' mental health, self-esteem, and motivation to engage in treatment and recovery efforts (Thoits, 2011).[46]

Instrumental Support:

Instrumental support involves tangible assistance, resources, or practical aid provided by one's social network. It may include financial assistance, transportation, childcare, housing, or help with daily tasks (Lakey & Cohen, 2000).[47] In the context of AUD, instrumental support plays a critical role in facilitating access to treatment services, transportation to appointments, and assistance with managing daily responsibilities, such as grocery shopping or household chores (Tracy & Johnson, 2007).[48] By addressing practical barriers to recovery, instrumental support enhances patients' ability to engage in treatment and maintain sobriety, ultimately improving treatment outcomes (Thoits, 2011).[49]

Informational Support:

Informational support entails the provision of advice, guidance, and information to help individuals make informed decisions. It may include recommendations for treatment options, coping strategies, or resources for addressing alcohol-related challenges (Lakey & Cohen, 2000).[50] In the context of AUD, informational support empowers patients to seek appropriate treatment, understand the consequences of alcohol use, and develop effective coping skills (Maddux & Rogers, 1983).[51] By increasing patients' knowledge and understanding of AUD, informational support reduces feelings of uncertainty and increases confidence in their ability to manage their condition, thereby enhancing treatment engagement and adherence.

Appraisal Support:

Appraisal support involves feedback, validation, and affirmation from others regarding one's thoughts, feelings, and experiences. It includes positive reinforcement, constructive criticism, and encouragement to foster self-esteem and self-efficacy (Thoits, 2011).[52] In the context of AUD, appraisal support boosts patients' confidence, motivation, and belief in their ability to change drinking behaviors (Tracy & Johnson, 2007).[53] It validates their efforts toward sobriety, celebrates their achievements, and provides encouragement during setbacks or

relapses. Appraisal support helps individuals develop a positive self-image and resilience in the face of challenges associated with AUD.

COGNITIVE BEHAVIOUR THERAPY

Cognitive Behavioral Therapy (CBT) is a widely recognized and effective treatment approach for alcohol use disorder (AUD), focusing on modifying both cognitive patterns and behavioral responses associated with problematic drinking behavior. CBT addresses the interconnectedness of thoughts, emotions, and behaviors, aiming to break the cycle of alcohol misuse. Cognitive restructuring is a fundamental part of CBT for AUD and entails recognizing and disputing illogical or maladaptive beliefs about alcohol consumption.

Through cognitive restructuring techniques, such as Socratic questioning and thought records, clients learn to examine the evidence for these beliefs and develop more balanced and realistic perspectives. By changing their thinking patterns, individuals can reduce their reliance on alcohol as a coping mechanism (Beck et al., 2011).[54]

Behavioral strategies are another essential element of CBT for AUD. These techniques focus on modifying specific behaviors associated with alcohol use, such as drinking in response to triggers or cues. Self-monitoring of drinking behaviors and triggers helps individuals identify patterns and triggers that contribute to their alcohol consumption. Through behavioral experiments and exposure exercises, clients learn alternative coping skills to manage cravings and high-risk situations effectively. Additionally, they engage in activities that provide alternative sources of reward and reinforcement, reducing the likelihood of relapse (NIAAA, 2014).[55] Relapse prevention is a key component of CBT for AUD, recognizing that setbacks are a natural part of the recovery process. Clients learn to identify early warning signs of relapse, such as negative mood states or social pressure, and develop coping strategies to address these challenges effectively. By creating a personalized relapse prevention plan, individuals are equipped with the skills and resources needed to maintain sobriety in

the face of potential triggers and stressors (Marlatt & Donovan, 2005).[56]

CBT for AUD emphasizes the importance of skill-building and generalization. Clients acquire problem-solving skills, assertiveness training, and effective communication techniques to navigate interpersonal relationships and social situations without relying on alcohol. These skills are practiced and reinforced in real-world contexts, promoting long-term behavior change and sustainable recovery beyond the treatment setting (Beck et al., 2011).[57] Cognitive Behavioral Therapy (CBT) offers a structured and evidence-based approach to treating alcohol use disorder (AUD). By targeting cognitive distortions, modifying maladaptive behaviors, and equipping individuals with coping skills, CBT empowers clients to achieve lasting behavior change and maintain sobriety over time. Integrating CBT with pharmacotherapy and other treatment modalities enhances treatment outcomes and promotes holistic recovery from AUD.

Effect of Cognitive Behavior Therapy on LOC

The implementation of cognitive-behavioral therapy (CBT) has shown effectiveness in enhancing the LOC among individuals struggling with substance use disorders. It can be inferred that the success of CBT interventions relies on well-structured, systematic modules, and the dedication of skilled and experienced therapists.

Following CBT principles, significant emphasis is placed on addressing beliefs and attitudes. Practitioners of CBT maintain that the interpretation of events holds greater significance than the events themselves. It is essential to identify cognitive distortions in individuals to gain insight into their core beliefs and establish a rapport with them. Clients are guided to document their thoughts and emotions, explore their fundamental beliefs, and examine their connection to current issues. Through a gradual process, inefficient beliefs are replaced with more adaptive ones. ((Cerel J et.al 2006).[58] In Rotter's learning theory, LOC encompasses both internal and external dimensions. Those with an E-LOC perceive their achievements and setbacks as

influenced by external factors like fate, chance, influential individuals, and unpredictable environmental conditions. Conversely, individuals with an internal LOC attribute their successes and failures to their actions and abilities. (Williams M, et. al; 2004.).[59]

Rotter's learning theory introduces the concept of LOC, distinguishing between internal and external orientations. Those with an E-LOC attribute their achievements and setbacks to external forces like fate, chance, influential figures, and unpredictable surroundings. Conversely, individuals with an I-LOC attribute their successes and failures to their own actions and abilities. Those with an internal orientation are often more socially adept, enjoying higher popularity and self-esteem. Additionally, they tend to experience less emotional instability, engage in fewer delinquent behaviors, and demonstrate greater resilience in coping with stress. (Mehrtak, et.al 2017).[60]

EFFECT OF COGNITIVE BEHAVIOR THERAPY ON EMOTIONAL INTELLIGENCE

Cognitive Behavioral Therapy (CBT) has been increasingly utilized to enhance emotional intelligence (EI) in various populations, including individuals with mental health disorders. CBT interventions targeting emotional intelligence typically focus on improving emotion recognition, understanding, expression, and regulation skills. CBT involves teaching individuals to identify and challenge maladaptive thought patterns and beliefs related to emotions. By recognizing and reframing negative thoughts, individuals can develop more adaptive emotional responses and coping strategies. Additionally, CBT techniques such as cognitive restructuring and mindfulness meditation are often incorporated to promote greater emotional awareness and regulation.

Rajabi and Karjou Kasmaee (2012) [61] highlighted the transformative potential of CBT in shaping individuals' perceptions of events, including those related to health, sickness, sadness, or loss. They suggested that CBT not only influences health outcomes but also contributes to overall well-being by fostering emotional development, adoption, and flexibility. By challenging maladaptive thought patterns and

encouraging a focus on positive aspects of life, CBT facilitates shifts in cognitive processing that promote emotional growth and well-being.

Several studies have demonstrated the effectiveness of CBT in enhancing emotional intelligence. Ruiz-Aranda et al. (2012)[62] found that CBT-based interventions significantly improved emotional intelligence in diverse populations, including clinical and non-clinical samples. Faye et al. (2013)[63] showed that a CBT intervention targeting emotional intelligence led to improvements in emotional awareness and regulation skills among college students.

CBT has been applied successfully in specific clinical populations to enhance emotional intelligence. Research supports the effectiveness of CBT in enhancing emotional intelligence and promoting psychological well-being. Studies have shown that CBT interventions lead to significant improvements in emotional awareness, regulation skills, and overall emotional functioning across diverse populations, including those struggling with depression, anxiety, and substance use disorders (Subramaniam et al., 2018).[64]

CBT offers a structured and evidence-based approach to enhancing emotional intelligence by targeting cognitive and behavioral processes underlying emotional functioning. By equipping individuals with practical skills to identify, understand, and manage their emotions, CBT interventions contribute to improved emotional well-being and adaptive functioning.

EFFECT OF COGNITIVE BEHAVIOR THERAPY ON PERCEIVED SOCIAL SUPPORT

P.S.S plays a crucial role in the treatment outcomes of alcohol use disorders, influencing individuals' ability to cope with challenges and maintain recovery. In their study focusing on alcohol dependence syndrome patients in a military hospital setting, Rajabi and Karjou Kasmaee (2012)[65] emphasized the significance of understanding social support perceptions within the context of treatment. They highlighted the limited exploration of social support's impact on treatment outcomes in the Indian population, prompting their

investigation into how social assistance is perceived among individuals with alcohol dependence syndrome.

Cognitive Behavioral Therapy (CBT) interventions, which target maladaptive beliefs and cognitive distortions, have shown promise in enhancing P.S.S. among individuals with mental health disorders (Heinrichs et al., 2006).[66] By addressing negative perceptions and enhancing coping skills, CBT can help individuals recognize and utilize available social support effectively, thereby improving treatment outcomes (Gould et al., 2012).[67]

McGovern et al. (2019) [68] emphasized the importance of social support networks in the recovery process for individuals with substance use disorders, underscoring the function of social support-based therapy enhancement strategies. Proudfoot et al. (2004) [69] highlighted the effectiveness of self-help programs based on CBT principles in improving P.S.S and reducing symptoms of depression and anxiety.

the impression of societal assistance among individuals with alcohol dependence syndrome is a crucial factor influencing treatment outcomes. Integrating CBT interventions that target cognitive processes and social skills may enhance P.S.S. and contribute to better treatment outcomes in this population.

Several investigations have been carried out. indicating that CBT is a beneficial therapy option that can be utilized for various substance use disorders. CBT works towards identifying triggers, helping to cope with cravings, identifying/changing negative automatic thoughts through cognitive restructuring, and enhancing problem-solving skills. Relapse risk was likewise decreased by CBT.

Although research has been done in this area, there is a lack of the same in the Indian community. CBT is considered the most effective treatment for individuals who are with AUD, However, not much research has been done on the variables that are now present in individuals with AUD.

The goal of the current study is to fill a gap in the literature by examining how CBT affects patients with substance use disorder

specifically alcohol use in terms of the LOC, perceived social support, and emotional intelligence of the patient.

AIM AND OBJECTIVES

1)To study the pre-post effect of Cognitive Behavioral Therapy (CBT) on Locus of control(LOC) in patients with substance use disorder(alcohol).

2)To study the pre-post effect of Cognitive Behavioral Therapy (CBT) on Emotional Intelligence in patients with substance use disorder (alcohol).

3)To study the pre-post effect of Cognitive Behavioral Therapy (CBT) On perceived social support (P.S.S) in a patient with substance use disorder(alcohol).

REVIEW OF LITERATURE

ALCOHOL USE DISORDER

1. Zeidonis et.al.,(1997)[70] – has highlighted the high prevalence of dual diagnosis in substance use disorder. Different combinations of psychiatric disorders are found to be associated with substance use. The author has highlighted the integrated treatment approach to tackle the diagnosis and prevent relapse.
2. In 1992, Sandoz conducted research involving 52 adults in Alcoholics Anonymous (AA)[71], consisting of 35 males and 17 females. This group was compared to a set of non-problem drinkers. The comparison focused on aspects such as LOC, emotional maturity, and parental intimacy. The study found notable distinctions between the AA group and the non-problem drinker group: the former exhibited a stronger belief in an external LOC, higher emotional dependency, and lower levels of intimacy with parents. Additionally, the research identified a direct correlation between the duration of sobriety and an internal LOC among those in recovery.
3. Buckman, Bates, and Morgenstern (2008)[72] aimed to build upon previous research regarding social support by investigating memory impairment and executive function in a more diverse population with substance use disorders. They adopted a person-centered approach to analyze social support for abstinence from alcohol and drugs among 122 individuals entering substance use treatment. The study compared substance use, executive dysfunction, and memory impairments, while also examining how impairment and social support influenced treatment outcomes. Three distinct social support classes were identified: (1) Frequent Positive Support, (2) Limited Positive Support, and (3) Negative Support. The Frequent Positive Support group exhibited the highest frequency of substance use and the most significant executive impairment upon treatment entry. However, by the end of treatment, they demonstrated substantial improvements in both areas.

4. Reel and McCrady (2010)[73] conducted a study to evaluate an integrated relapse model, incorporating hypotheses from interpersonal and intra-individual relapse models. The study aimed to investigate whether the relationship between alcohol-specific social support and drinking outcomes could be partially explained by motivation. The research involved 158 women with alcohol use disorders. Two trials were conducted: one comparing cognitive behavioral therapy (CBT) for alcohol use disorders, with female-specific CBT, and the other comparing alcohol-behavioral couple therapy with a blend of individual CBT and alcohol-behavioral couple therapy. Social support variables were assessed using the Important People Interview. The findings of the study indicate that motivation serves as one mechanism through which abstinence-specific social support influences treatment outcomes.
5. LaRocca and Scogin's (2015)[74] study delves into the significance of social support in the improvement of quality of life as a result of home-delivered cognitive behavioral therapy (CBT). The research involved 137 participants, predominantly identified as rural, economically disadvantaged, and frail, who were randomly assigned to receive either CBT or a minimal support control condition. Through hierarchical regression analysis, it was found that a positive shift in satisfaction with social support correlated with enhanced quality of life, surpassing the effects of CBT alone. Furthermore, the study identified both pre-treatment satisfaction with social support and the impact of CBT on quality of life. These findings suggest that enhancing social support alongside CBT may amplify improvements in quality of life.
6. Masjedi and Taghavizadeh (2015)[75] researched to evaluate the efficacy of cognitive-behavioral group therapy (CBT) training in enhancing the general health and emotional intelligence of male adolescents. The study employed a semi-experimental design with pretest-posttest measurements and included two experimental groups and two control groups during the 2014-2015 academic year. A total of 40 male high school students were divided equally divided

test and control groups (each comprising 20 students). Participants completed assessments using the Baron Emotional Intelligence and GHQ-28 scales. Subsequently, the test group underwent eight sessions of CBT training, while the control group did not receive any interventions. Both groups were assessed post-intervention, and the data were analyzed by administering a multivariate analysis of covariance in SPSS-20. The results indicated that CBT practice effectively improved emotional intelligence and general health in adolescent male students.

7. Prakash and Sharma (2015)[76] aimed to evaluate personality disorder (PD), emotional intelligence (EI), and LOC among patients with alcohol dependence (AD) and compare them with those of normal controls. They selected 33 AD patients from the De-Addiction Ward of RINPAS and 33 matched normal subjects from Ranchi and nearby areas. Both groups were assessed based on various sociodemographic parameters including age, gender, and socioeconomic status. All participants underwent evaluation using the Millon Clinical Multiaxial Inventory-III, Mangal EI Inventory, and LOC scale. Standard scoring methods were employed, and statistical analysis was conducted using the Chi-square test. The study found that AD patients exhibited significantly higher rates of PDs, lower levels of EI, and a tendency towards an external LOC orientation. Recognizing and addressing these concurrent conditions could potentially enhance the management and outcomes of AD.
8. Hussin and Salimah Alias (2015)[77] conducted a study to investigate the efficacy of the Brief Cognitive Behavioral Therapy module in enhancing LOC among individuals with substance abuse issues. Employing a quasi-experimental design with one treatment group (CBT (B)) and one control group (KW), the study involved four measurements (pre-, post 1, post 2, and post 3). A sample of 108 drug abusers was selected using purposive sampling, and then randomly allocated into the CBT (B) and control groups, each comprising 36 participants. Data collection utilized standardized psychometric tools, including the internal control index (Patricia

Duttweiler, 1984) and the Rosenberg Self-Esteem Scale. Overall, the study demonstrates that the CBT (B) intervention has the potential to enhance LOC among individuals with substance abuse issues.

9. Nikmanesh Baluchi (2016)[78] researched to explore the influence of self-efficacy beliefs and social support in predicting addiction relapse. The study involved a population of 166 participants, comprising 83 individuals who had experienced relapse and 83 who had not, selected through snowball sampling over four months of voluntary participation in treatment centers. Variables were assessed using measures such as the general self-efficacy scale and the multidimensional scale of perceived social support. The study's findings suggest that both self-efficacy beliefs and social support play significant roles in preventing addiction relapse among patients.
10. Ghahari and Atefvahid (2020)[79] conducted a study within Drug Addiction Centers in Tehran, aiming to explore the impact of low emotional intelligence on individuals' coping strategies, which is considered one of the risk factors for addiction. Participants were screened using The Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II) to identify personality disorders. Thirty-six individuals were randomly selected and assigned to two groups of 18 members each. The experimental group underwent cognitive-behavioral techniques for 12 sessions, while the control group remained on a waiting list. Both groups were assessed at baseline, session 6, end of treatment, and a 3-month follow-up. Results indicated that the experimental group exhibited significant improvements compared to the control group across all measurement times, particularly in interpersonal, intrapersonal, general mood, adaptability, and stress tolerance scales. The study suggests that the cognitive-behavioral approach can positively impact the enhancement of emotional intelligence among cannabis users.

11. Zaidi (2020)[80] conducted a study focusing on addiction, a disorder with behavioral and psychological roots that can lead to significant social, mental, and physiological consequences. The influence of a patient's surroundings, including their neighborhood, peers, family, and spouse, is crucial in preventing relapse. The primary aim was to explore the importance of social support in relapse prevention, analyzing aspects such as drug abuse, addiction as a psychological condition, and the benefits of social support in this context. Additionally, the review offers suggestions for future research endeavors aimed at decreasing the prevalence of substance use and relapse. It emphasizes that both digital and in-person social support systems are effective in fostering a sense of purpose among individuals struggling with addiction and alleviating feelings of social isolation
12. Li and Saeed (2020)[81] investigated the mediating role of life satisfaction and the predictive influence of perceived social support on internet addiction, considering the moderating factor of ethnicity. The study involved African and South Asian foreign learners residing in Xian, China, for a minimum of six months. The questionnaire included sections on demographics and utilized the Multidimensional Scale of Perceived Social Support (MSPSS) to gauge perceived social support (PSS), the Satisfaction with Life Scale to assess life satisfaction (LS), and the Problematic and Risky Internet Use Scale (PRIU) to evaluate internet addiction (IA) among participants. Results indicated a significant correlation between perceived social support and life satisfaction, as well as a noteworthy negative relationship between life satisfaction and both the direct effect of PPS on IA and the indirect effect of PSS on IA through LS, across both ethnic groups (African and South Asian). These findings underscore the implications for addressing internet addiction among international students.
13. Hashemi and Hashemi (2019)[82] conducted a study aiming to investigate the correlation between the presence of social support and the risk of drug abuse. It was experimental, employing a pre-test

and post-test design, with 30 patients randomly allocated into experimental and control groups. The primary objective was to evaluate the impact of an 8-session stress management training program, based on cognitive-behavioral techniques. Participants were assessed at the beginning and end of the program using the Social Support Questionnaire (SSQ). The findings suggest that interventions rooted in cognitive-behavioral approaches are effective in modifying behavioral and cognitive factors linked to substance use, making them a valuable model for both preventing drug abuse and aiding in post-treatment support.

14. Reyes and Rossi (2022)[83] conducted a study focusing on the impact of substance misuse among Black emerging adults, a demographic significantly affected by this issue. They found that posttraumatic stress disorder (PTSD) correlates with increased substance misuse in this population. However, there has been limited research into protective factors that could potentially mitigate the association between PTSD and substance misuse in this group. To address this gap, the study involved 182 trauma-exposed Black emerging adults who completed self-report measures assessing PTSD symptoms, alcohol and drug misuse, and perceived social support. The results indicate the potential importance of addressing social support as part of the assessment and treatment of substance abuse in trauma-exposed Black emerging adults.
15. Jarnecke (2022)[84] investigates the potential significance of social support as a crucial factor in treating concurrent substance use disorder (SUD) in addition to posttraumatic stress disorder (PTSD). No prior studies have explored how social support evolves during treatment or predicts treatment outcomes among veterans with both SUD and PTSD. This study, therefore, represents a secondary analysis aimed at examining changes in social support throughout the treatment process for individuals with co-occurring SUD and PTSD (N = 81). The analysis sought to determine whether social support predicts changes in social support levels during treatment and follow-up. The results underscore the vital role of social support

during treatment in improving outcomes for individuals grappling with co-occurring SUD and PTSD.

16. Shiraz and Ghoochani (2022)[85] conducted a study to explore the correlation between resilience, LOC, and emotional intelligence among opium addicts. The study involved 40 male opium addicts selected through convenience sampling. Utilizing demographic questionnaires in this cross-sectional study, the correlation coefficient was obtained using Pearson's test. The findings indicate that addiction treatment centers should assess and enhance levels of resilience, emotional intelligence, and the type of LOC in addicts within the age range of 20 to 25 years. Moreover, the results suggest that cognitive behavioral therapy (CBT) influences LOC, emotional intelligence, and the role of perceived social support in substance use treatment.
17. Patel and Sharma (2022)[86] conducted a study to explore the connection between patterns of alcohol use with LOC and impulsivity. This cross-sectional study was carried out among hospitalized patients diagnosed with alcohol use disorder (AUD) in a tertiary care hospital in Western India. The participants, aged between 18 and 65 years, were diagnosed with AUD according to DSM-5 criteria after undergoing acute detoxification. Sociodemographic information was collected using an interview format, and assessments included the Alcohol Use Disorder Identification Test, the Drinking-Related LOC Scale, and Barrett's Impulsiveness Scale 11 (in Gujarati versions). The study encompassed a total of 65% of middle-aged participants (aged 35–50 years), predominantly from rural areas. The findings revealed a robust association between external LOC (LOC) and impulsivity with alcohol use. Individuals with higher levels of external LOC and impulsivity tended to have an earlier age of first alcohol intake, more severe alcohol use, and longer durations of alcohol consumption.

Locus of Control

18. Adamson, Sellman, and Frampton (2008)[87] conducted a study examining the characteristics of patients undergoing treatment for

alcohol use disorder across three dimensions. The research identified several consistent predictors of treatment outcomes, including initial alcohol consumption levels, severity of dependence, employment status, gender, and psychopathology rating. Additionally, treatment history, neuropsychological functioning, alcohol-related self-efficacy, motivation, socioeconomic status/income, treatment goals, and religious affiliation were scrutinized. Predicting treatment outcomes offered three significant advantages in clinical settings: identifying specific client groups with poorer outcomes, identifying areas for intervention within treatment, and improving prognosis accuracy. The study employed online databases such as Psych Lit, Medline, and Embase, with inclusion criteria limited to human subjects, English language, adults aged 18–64 years, and publication dates from 1977 to 2005. Among the predictor variables examined, baseline alcohol consumption and severity of dependence ranked among the top three most extensively studied variables.

19. Patel, Sharma, Mahida, and Mistry (2022)[88] conducted a study examining the relationship between LOC (LOC), impulsivity, and alcohol consumption patterns among hospitalized patients diagnosed with alcohol use disorder (AUD) in Western India. This cross-sectional analytical research involved 116 AUD patients post-acute detoxification. Standardized scales were utilized to evaluate LOC, impulsivity, and the severity of alcohol use. The findings revealed a significant association between external LOC, impulsivity, and alcohol consumption patterns. Specifically, individuals with high external LOC and impulsivity tended to initiate alcohol consumption at a young age, display severe alcohol use, and experience higher relapse rates. This highlights the role of psychological factors such as external LOC and impulsivity in shaping alcohol consumption behaviors and the likelihood of relapse among individuals with AUD. These results underscore the necessity for targeted interventions addressing these psychological factors alongside traditional treatment approaches to improve treatment outcomes and reduce

relapse rates in AUD management. Further longitudinal research is recommended to explore the enduring effects of interventions targeting LOC and impulsivity in AUD treatment.

20. Lassi et al.[89] conducted a study examining the connection between LOC and tobacco/alcohol consumption among young adults, utilizing data from the Avon Longitudinal Study of Parents and Children (ALSPAC). Their hypothesis proposed that individuals with a more external LOC would be at an increased risk of tobacco and alcohol use. Through logistic regression analysis, they found that individuals with an E-LOC at age 16 were more likely to be weekly smokers at ages 17 and 21, and they exhibited signs of nicotine dependence at both ages. Furthermore, those with an E-LOC displayed a higher likelihood of hazardous drinking at age 17, though this association was not evident at age 21. These results indicate that LOC could be addressed in interventions targeting substance use and dependence prevention, highlighting the importance of psychological factors in understanding and tackling substance use behaviors among young adults.
21. Dahal et al.[90] build upon existing research examining the relationship between (LOC) and motivation to modify alcohol consumption habits among individuals diagnosed with Alcohol Use Disorder (AUD). Previous studies have shown that an individual's belief regarding control over their drinking behaviors, whether internal or external, can significantly influence their readiness and commitment to initiating and sustaining behavior change. This study adds to this body of knowledge by specifically investigating how drinking-related LOC impacts motivation among male patients with AUD in Kathmandu, Nepal. The findings align with previous research, suggesting that individuals with an internal LOC are more likely to be motivated to alter their drinking behavior compared to those with an external LOC. These results underscore the importance of addressing LOC in interventions designed to promote behavior change and support recovery among individuals with AUD. However, the study highlights the need for further longitudinal

research to confirm these findings and evaluate the efficacy of interventions targeting LOC in AUD treatment. Overall, this study offers valuable insights into the literature on AUD treatment and underscores the importance of understanding psychological factors such as LOC in improving positive outcomes in recovery efforts.

22. Cheng and Furnham (2019)[91] conducted an extensive examination of the predictors of alcohol consumption and binge drinking behavior in adulthood using data from the 1970 British Cohort Study (BCS70). Their study encompassed various psychological and socio-demographic factors assessed from childhood to adulthood, including parental social class, LOC, psychological distress, educational achievement, occupational status, and gender. Their findings revealed several notable associations: male gender, lower parental social class, external LOC during adolescence, psychological distress, lower childhood intelligence, lower educational attainment, and less prestigious occupations were all correlated with increased adult binge drinking. Importantly, hierarchical logistic regression analyses demonstrated that these factors, including LOC beliefs, psychological distress, educational achievement, and occupational status, independently predicted adult binge drinking. Notably, the study highlighted the lasting impact of adolescent LOC beliefs on adult binge drinking behavior, emphasizing the complex interaction of psychological and socio-demographic factors in shaping alcohol consumption patterns across the lifespan.
23. Adamson, Sellman & Frampton (2009)[92] conducted a systematic review focusing on patient predictors of treatment outcomes for alcohol use disorder. The researchers examined patient characteristics as predictor variables at three levels. These predictor variables included alcohol consumption, severity of dependence, employment status, and gender. Additionally, they considered psychopathology rating, treatment history, neuropsychological functioning, as well as alcohol-related self-efficacy, motivation, socioeconomic status/income, treatment goals, and religion.

Notably, alcohol consumption and gender exhibited substantial reductions in predictive consistency in the test findings, while other variables did not show significant impacts. The study aimed to identify variables that could provide significant findings to improve prognostication, enabling clinicians to better inform clients and their families about potential outcomes. This allows for enhanced treatment planning regarding intervention type, duration, and intensity (Kadden & Skerker, 1999). The researchers limited their search to human subjects, English language, adults aged 18–64, and publication dates from 1977 to 2005. Thirty-one baseline predictors were identified from these papers, and their ability to predict drinking-related treatment outcomes was assessed. Gender emerged as a significant predictor in half of the reviewed studies, along with religion, albeit investigated in only four studies. On the other hand, age, marital status, education, and ethnicity were generally poor predictors. Some of the identified variables underscore the potential significance of patient group and treatment setting.

24. Hussin, Alias, Othman, et al. (2015)[93] sought to explore the efficacy of a concise cognitive-behavioral therapy (CBT) program on LOC among individuals grappling with substance abuse. They observed that those struggling with addiction often perceive themselves as capable of retaining control over their actions and maintaining their freedom, despite needing treatment to reclaim their full potential. Using a quasi-experimental design, the researchers established one treatment group and one control group, comprising a total of 108 drug abusers selected through purposive sampling. The findings indicated notable disparities in LOC mean scores across various time points, with an interaction effect observed between group and time points on these scores. Furthermore, the study demonstrated that the CBT intervention resulted in an elevation of LOC mean scores among the participants. The study concludes that structured and systematic modules, alongside dedicated, skilled, and experienced counseling methods and

therapeutic interventions utilizing the CBT approach, can yield favorable outcomes. Additionally, early intervention emphasizing the establishment of personal goals and training in cognitive restructuring techniques based on CBT principles can play a crucial role in addiction treatment.

25. Frenette, Ouellet, Guay, et al. (2022)[94] aimed to assess the provision of emotional and tangible support after a 12-session Internet-based cognitive behavioral therapy (ICBT) intended to address symptoms of post-traumatic stress (PTS), insomnia, and depression. They also examined the relationship between post-treatment symptoms and emotional and tangible support. The study recruited 178 participants. The findings indicated that completing the treatment resulted in an augmentation of emotional support. Furthermore, reduced post-treatment symptoms of PTS and insomnia were associated with higher levels of emotional support post-treatment. Therefore, cognitive behavioral therapy may contribute to enhancing emotional support by alleviating symptoms, particularly when directly addressing social support as part of the treatment.

Emotional Intelligence in Alcohol dependent patients

26. Kopera, Brower, Suszek, et al. (2017)[95] explored the connection between facets of emotional intelligence and physical pain among individuals diagnosed with alcohol dependence (AD). They enrolled 103 participants from an alcohol treatment facility in Warsaw, Poland, categorizing them into two groups based on the intensity of their pain: those with "mild or no pain" and those with "moderate or severe pain." Logistic regression modeling was then applied. The results indicated an investigation into the relationship between the current severity of anxiety and depressive symptoms and pain severity, with emotion regulation serving as a mediator. It was discovered that emotion regulation fully mediated the link between the severity of depression and pain, while partially mediating the connection between the severity of anxiety and pain. These findings imply that implementing comprehensive strategies to improve mood

regulation skills could be advantageous in treating AD patients experiencing concurrent pain symptoms.

27. Coelho's (2012)[96] research emphasizes the significance of emotional intelligence (EI) as a valuable asset in averting alcohol and other drug (AOD) misuse among adolescents and adults. Unlike conventional intervention approaches that typically tackle problematic behaviors after they have surfaced, Coelho advocates for prevention programs that proactively target behavior modification before issues arise. EI, characterized by emotional competence and social and emotional learning, plays a crucial role in cultivating healthy behaviors and has been linked to a reduction in risk factors associated with AOD misuse. By acknowledging EI as a desirable trait for promoting overall health and well-being, Coelho proposes its integration into prevention-oriented frameworks aimed at curbing high-risk behaviors associated with AOD misuse. This highlights the potential of EI-focused interventions to address underlying emotional triggers contributing to substance misuse and facilitate enduring behavioral changes among adolescents and adults.
28. Obeid et al.'s (2021)[97] study investigates the intricate relationship between emotional intelligence (EI) and various mental health factors among adults in Lebanon, focusing on a relatively unexplored area within the Lebanese context. Expanding upon previous literature that has already established associations between EI and emotional aspects such as stress, depression, and anxiety, this research widens its scope to include a broader range of mental health issues, such as social anxiety, alcohol use disorders (AUD), work-related fatigue, and alexithymia. Using cluster analysis, the study identifies three distinct EI profiles, classifying participants into low, moderate, and high EI clusters. Notably, individuals with lower levels of EI exhibited a higher prevalence of AUD, alexithymia, anxiety, depression, stress, social phobia, and work-related fatigue compared to those with moderate or high EI. These findings highlight a significant correlation between EI and mental health outcomes, underscoring the importance of interventions aimed at

addressing alcohol misuse and psychological distress within the Lebanese population.

29. Kun and Demetrovics (2017)[97] conducted a systematic review focusing on Emotional Intelligence and Addictions, examining the relationship between emotional intelligence (EI) and both physical and mental health. Through a thorough analysis of the literature, they discovered that a lower level of EI is associated with more severe alcohol and illicit drug use, with specific components of EI playing pivotal roles in addiction, particularly in the "decoding and differentiation of emotions" and the "regulation of emotions." The review traces the concept of substance use as a coping mechanism for overwhelming emotional states back to Rado (1933), who initially described it as such. McDougall (1984) further emphasized the importance of managing overwhelming emotions in individuals with addictive disorders, identifying substance use as a compulsive method of coping with these emotions. This perspective is elaborated upon in the theories of Leon Wurmser and Edward J. Khantzian. According to Wurmser (1974), individuals with addictive disorders struggle to regulate their emotions, impulses, and internal stress, leading them to resort to psychoactive substances. Additionally, Kornreich and colleagues observed that the ability to recognize emotions is closely and inversely associated with interpersonal difficulties, with these difficulties acting as a mediating factor between deficits in emotional recognition and alcoholism (Kornreich et al., 2002).
30. Berking, Margraf, Ebert, et al. (2011)[98] carried out a study emphasizing the role of deficiencies in adaptive emotion-regulation abilities in contributing to alcohol dependence (AD). Several theories suggest that regulating emotions is a primary motivator for alcohol consumption, including the affective processing model (Baker, Piper, McCarthy, Majeskie, & Fiore, 2004). The study involved 116 individuals undergoing treatment for AD and participating in Cognitive Behavioral Therapy (CBT). Self-report questionnaires were used to assess Emotional Intelligence and the severity of AD

symptoms. Analysis conducted before and after treatment showed that pre-treatment emotion-regulation skills predicted alcohol use during treatment, while post-treatment emotion-regulation skills predicted alcohol use during follow-up, even after considering other factors potentially linked to emotion regulation. Additionally, the results indicated that individuals in the AD sample reported significantly greater deficits in emotion-regulation skills.

Perceived social support

31. Dahal and Koirala (2021)[99] explore the relationship between perceived social support and the willingness to change drinking behavior among male patients diagnosed with Alcohol Use Disorder (AUD) in Kathmandu, Nepal. Given the widespread traditional use of alcohol among different ethnic groups in Nepal, the study seeks to ascertain whether perceived social support from family and friends contributes to the rehabilitation process for individuals with AUD. Using data from a sample of 225 male patients from alcohol and drug rehabilitation centers, the study finds that over 50% of participants expressed uncertainty regarding the change process. However, it highlights a significant association between perceived social support and the desire to alter drinking behavior, suggesting that social support may play a positive role in fostering motivation for recovery. These findings emphasize the importance of recognizing social support mechanisms in AUD treatment and recovery efforts, underscoring the potential of familial and peer support networks to positively influence individuals' resolve to address problematic drinking habits.
33. Rathinam and Ezhumalai's (2022)[100] study explores the crucial aspect of perceived social support among individuals who have abstained from substance use disorder (SUD), shedding light on a significant facet of addiction recovery. Carried out in Bangalore, India, the cross-sectional study involved sixty participants who were receiving follow-up services at an outpatient specialty clinic for addiction medicine. The findings revealed noteworthy patterns: the

majority of participants did not report peer pressure, were diagnosed with alcohol dependence, and had a history of previous abstinence. Interestingly, the average score of perceived social support among individuals abstaining for three months or longer indicated high levels of support. These results highlight the importance of social support networks in facilitating and sustaining abstinence from substance use. Understanding the dynamics of perceived social support in abstinent individuals contributes to the development of interventions aimed at promoting long-term recovery and addressing the multifaceted challenges associated with substance use disorders.

34. Brooks et al.'s (2017)[101] qualitative exploration delves into the intricate dynamics of social support during treatment for severe alcohol use disorder (AUD) and the subsequent journey of recovery. Through interviews with 33 individuals with severe AUD transitioning from inpatient rehabilitation to community settings, the study seeks to comprehend shifts in social networks and their impact on maintaining sobriety. Thematic analysis revealed instrumental and emotional support as prominent forms of social support, with Alcoholics Anonymous (AA) frequently mentioned as a significant source of support. Participants often idealized the supportive environment of the inpatient program, emphasizing its role in shaping their recovery path. The findings underscore the importance of addressing social support networks as individuals transition between treatment settings and reintegrate into the community. From an intervention perspective, the study emphasizes the significance of assisting individuals in selecting environments and social contexts conducive to sustaining sobriety. These insights provide valuable guidance for clinicians in tailoring interventions to meet the unique social support needs of individuals undergoing AUD treatment and recovery, facilitating the establishment and maintenance of healthy social networks crucial for long-term sobriety.

35. Sacco, Bucholz, and Harrington's (2014)[102] study explores the intricate connections among stressful life events, perceived stress, social support, and alcohol consumption among older adults, with a specific emphasis on gender differences. Drawing upon data from the National Epidemiologic Survey of Alcohol and Related Conditions, the research investigates how these factors interact with alcohol use patterns in individuals aged 60 and older. The findings reveal nuanced gender-specific associations; while stressful life events are linked to alcohol use disorder (AUD) in both men and women, crime victimization specifically correlates with AUD among men. Interestingly, higher perceived stress is associated with decreased alcohol consumption among women but increased odds of AUD in men, indicating a complex interplay between stress and alcohol use that varies by gender. These findings underscore the importance of considering gender-specific dynamics in understanding alcohol consumption behaviors among older adults, providing valuable insights for tailored interventions and support strategies aimed at reducing alcohol-related risks within this demographic.
36. Harandi, Taghinasab, and Dehghan Nayeri[103] conducted a meta-analysis to explore the relationship between social support and mental health based on studies conducted in Iran spanning from 1996 to 2015. By analyzing data from 64 relevant studies, the meta-analysis revealed a moderate effect size of social support on mental health, with mean effect sizes of 0.356 and 0.330 under fixed-effect and random-effect models, respectively. These findings highlight a significant association between social support and mental health, underscoring the importance of fostering robust social support networks, particularly among vulnerable populations such as women, the elderly, patients, workers, and students. The study suggests that enhancing social support mechanisms could play a crucial role in promoting mental well-being across various demographic groups. Additionally, the analysis indicated no evidence of publication bias among the studies, although there was

heterogeneity in effect sizes. This underscores the need for tailored interventions aimed at bolstering social support systems to improve mental health outcomes.

37. Birtel, Wood, and Kempa (2017)[104] conducted a study investigating the connections between stigma, social support, and mental health outcomes among individuals undergoing treatment for substance abuse. The study involved 64 participants dealing with substance abuse issues and examined the influence of perceived stigma on mental health and well-being, as well as whether internalized stigma and shame act as mediators in this relationship. The findings revealed that perceived stigma was associated with lower self-esteem, higher levels of depression and anxiety, and poorer sleep quality. Conversely, perceived social support was linked to higher self-esteem, lower levels of depression and anxiety, and better sleep quality. Importantly, the impact of perceived stigma and social support on mental health outcomes was mediated by internalized stigma and shame. These results suggest that leveraging social support networks could mitigate the adverse effects of internalized stigma and shame on mental health and well-being among individuals struggling with substance abuse issues, underscoring the importance of interventions aimed at bolstering social support systems to improve mental health outcomes in this population.

39. Gavurova, Ivankova, and Rigelsky[105] conducted a study to explore the connections between perceived stress, depression, and alcohol use disorders among Slovak university students amid the COVID-19 pandemic. By analyzing data from 1523 students collected through electronic questionnaires, the researchers employed descriptive, regression, and correlation analyses. The findings unveiled a heightened level of perceived stress among female students, whereas male students displayed a greater prevalence of alcohol use disorders. Noteworthy differences in mental and behavioral disorders were observed across gender and income categories. Crucially, the study identified a positive correlation between perceived stress and depression, as well as between depression

and alcohol use disorders. These results indicate that interventions targeting stress reduction could potentially lead to a decrease in both depressive symptoms and excessive alcohol consumption among university students. This underscores the potential significance of integrating stress management strategies into mental health interventions tailored for this demographic during crises such as the COVID-19 pandemic.

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41. Laaksonen, Vuoristo-Myllys, Koski-Jannes, and Alho (2013)[107] conducted a study on the efficacy of combining medical treatment with cognitive-behavioral therapy (CBT) in treating alcohol-dependent patients, focusing on its effects on life quality (QL) and general well-being. The study employed a randomized, open-label, multi-center naturalistic design involving 243 voluntary treatment-seeking alcohol-dependent adult outpatients. The treatment comprised two phases: the first phase lasted 12 weeks, with

continuous medication followed by targeted medication for up to 52 weeks, and the second phase included a follow-up period of 67 weeks. Participants were randomly assigned in a 1:1:1 ratio to receive supervised naltrexone, acamprosate, or disulfiram, along with a brief manual-based cognitive-behavioral intervention (CBT). Results indicated that all three study groups exhibited a significant difference. In the EQ-5D quality of life test, patients showed significant positive changes in dimensions related to sleeping, mobility, pain, and mood. Moreover, the severity of depression decreased throughout the study duration. The combination of medical treatment with CBT appeared to contribute to the reduce depression symptoms and improvement in quality of life among patients. Furthermore, the treatment was associated with success in smoking cessation efforts.

Cognitive Behaviour Thearpy

43. Brown et al. (1997)[109] conducted a study that focused on cognitive-behavioral treatment for depression in individuals with alcoholism. Nineteen subjects participated in the study and were divided into two groups: one receiving eight individual sessions of cognitive-behavioral treatment for depression (CBT-D), and the other receiving relaxation training control plus standard alcohol treatment (RTC). The results revealed that patients undergoing CBT-D experienced greater reductions in somatic depressive symptoms, depressed mood, and anxious mood compared to those in the RTC group during treatment. Furthermore, CBT-D patients showed a higher percentage of days abstinent during the initial 3-month follow-up period, although there were no significant differences in overall abstinence or drinks per day between the two groups. In between the 3- and 6-month follow-ups, CBT-D patients it is significantly better alcohol use outcomes, including total abstinence, percentage of days abstinent, and drinks per day, compared to RTC patients.
44. Jon Morgenstern and Richard Longabaugh (2002)[110] conducted a systematic review that examined cognitive-behavioral treatment

(CBT) for alcohol dependence, aiming to evaluate whether CBT operates by improving cognitive and behavioral coping skills. The review analyzed ten studies, all of which employed random assignment of participants to CBT and at least one other comparison condition. Despite conducting various analyses to investigate the potential causal connections between CBT and enhanced coping skills, the results offered only limited support for the hypothesized mechanisms of action of CBT.

45. Kalivas and colleagues (2005)[111] emphasize the neural mechanisms involved in addiction, highlighting that modifications in the brain's reward system result in decreased responsiveness to natural rewards, impaired cognitive control, and increased reactions to drug-related cues. Specifically, alterations in prefrontal glutamatergic signaling to the nucleus accumbens play a role in impulsive drug-seeking behavior. To target these compulsive and impulsive tendencies observed in individuals with substance use disorders, clinical psychologists utilize cognitive-behavioral therapy (CBT) interventions.
46. Barry and colleagues (2014)[112] conducted research that unveiled participants' unfavorable perceptions of individuals grappling with substance use disorder. Respondents showed disapproval regarding having substance users within their families or working closely with them. Additionally, they exhibited a greater readiness to tolerate discriminatory behavior against drug addicts, expressed skepticism regarding the efficacy of treatment, and displayed a tendency to oppose programs designed to aid them.
47. Aggarwal and colleagues (2013)[113] conducted research centered on drug dependence and alcohol consumption among adolescents. The study unveiled that a notable proportion of adolescents, predominantly from nuclear families (63.5%), urban backgrounds (83.5%), and with a dropout status from school (54.1%), were engaged in substance use. The research also outlined the specific drugs frequently consumed by adolescents. Additionally, it was

discovered that almost half of the participants (40.2%) had a familial history of drug dependence or alcohol consumption.

48. Randhawa and colleagues (2020)[114] conducted research concentrating on the socio-demographic attributes of patients accessing de-addiction services at a medical college in Punjab. The sample had 200 patients, all of whom were male, with 50% falling within the age bracket of 25-35 years. The majority of participants (38%) were classified as belonging to the lower-middle socio-economic status.
49. Chavan and colleagues (2019)[115] conducted a study on the occurrence of Substance Use Disorders (SUDs) in Punjab, employing a sample of 2895 individuals from four districts. The results show that 80% of the participants had attained a high school education, and 70% were married. Remarkably, the prevalence was most pronounced among individuals aged 30-39 years, living in urban metropolitan areas, and those with lower educational attainment levels.
50. In Sher's (2016)[116] investigation, the link between criminal behavior and the consumption of alcohol and drugs is highlighted. The study suggests that violent crimes were connected to both immediate intoxication and the need for finances to support the use of expensive drugs among individuals grappling with dependence. The findings indicate that involvement in cultures and markets associated with alcohol and drug consumption was associated with various types of criminal activity.

51. Schuckit, M. A. (1987)[117] conducted a review of research concerning the biological factors associated with the risk of alcoholism. The study indicates that the disorder has a genetic influence, with men being at a higher risk of developing alcoholism. Promising markers of biological vulnerability to alcoholism include reduced reactivity to moderate doses of ethanol among sons of alcoholics compared to control subjects, diminished amplitude of specific brain waves in event-related potentials, and a distinct

pattern of background cortical electroencephalograms in young men at high risk for future alcoholism.

52. Rangé and Marlatt (2008)[118] delve into Cognitive-behavioral therapy (CBT) as a treatment approach for alcohol and drug use disorders, underscoring the significant impairment and complexities associated with substance-related issues. These challenges often lead to deteriorating overall health and adverse effects on personal, social, and professional aspects of life. The study suggests that working with individuals grappling with alcohol and/or drug abuse can be demanding yet intrinsically fulfilling. Therapists must maintain focus when addressing the needs of addicted patients, avoiding conveying hopelessness While therapists provide feedback, education, techniques, and support, they cannot resolve the patient's challenges on their behalf. It's crucial for therapists to remain composed during critical situations and assist patients in problem-solving, recognizing the importance of patients taking ownership of their recovery journey.

53. Marques and Formigoni (2001)[119] conducted a study comparing the effectiveness of individual and group cognitive-behavioral therapy for patients dependent on alcohol and/or drugs. The study included 155 participants with alcohol dependence, randomly assigned to either individual or group therapy sessions. The treatment spanned two phases: acquisition and maintenance, lasting for 8 months. After follow-up assessment, both groups exhibited similar levels of drug consumption, dependency, and related issues. Compliance with treatment and the severity of drug use were identified as predictors of success among drug-dependent individuals. The results suggest that both treatment approaches produced comparable outcomes, indicating that the group format, which may offer a more favorable cost-benefit ratio, could be implemented without compromising compliance or efficacy.

54. McHugh, Hearon, and Otto (2010)[120] conducted a study on Cognitive Behavioral Therapy (CBT) for Substance Use Disorders (SUDs), reviewing evidence from several large-scale trials and quantitative reviews. Their meta-analytic review specifically focused on CBT's efficacy for drug abuse and dependence, analyzing 34 randomized controlled trials involving 2340 treated patients. The findings consistently supported the effectiveness of CBT for alcohol and drug use disorders, with an overall effect size falling within the moderate range (d = 0.45). Effect sizes varied from small (d = 0.24) to large (d = 0.81) depending on the targeted substance. CBT for SUDs encompasses a diverse array of behavioral treatments, including those addressing operant learning processes, motivational barriers to improvement, and various other cognitive-behavioral interventions. These interventions, whether used alone or in conjunction with pharmacotherapy, have demonstrated efficacy in controlled trials, offering promise for achieving more robust treatment outcomes.

55. Vedel, Emmelkamp, and Schippers (2008)[121] conducted a comparative study to evaluate the effectiveness of Individual Cognitive-Behavioral Therapy (CBT) and Behavioral Couples Therapy (BCT) for Alcohol Use Disorder. They conducted a randomized clinical trial involving Dutch male and female alcoholics and their partners in community treatment centers, with 30 participants receiving stand-alone BCT and 34 participants receiving individual CBT. The study found that both BCT and CBT were effective in altering drinking behavior post-treatment, with no significant superiority of BCT over CBT observed. However, spouses' marital satisfaction notably increased in the BCT condition compared to the CBT condition, a difference that was significant in the post-test assessment. Additionally, patients' self-efficacy in handling alcohol-related high-risk situations improved significantly in both treatment conditions, with a slightly greater enhancement observed in CBT compared to BCT after treatment. Despite involving

the spouse in treatment, there was no observed increase in retention. Overall, the findings suggest that practitioners in community treatment centers can effectively administer both treatments. Stand-alone BCT is equally effective as CBT in reducing drinking and somewhat enhances relationship satisfaction. However, it's important to note that BCT is a more resource-intensive intervention due to longer treatment sessions compared to individual CBT sessions.

56. Kadden (2001)[122] conducted a review focusing on Behavioral and Cognitive-behavioral treatments for alcoholism, aiming to identify gaps in knowledge and potential research opportunities. The author emphasized the utilization of various techniques within Cognitive Behavioral Therapy (CBT) as part of treatment interventions for individuals with alcohol use disorder, often in conjunction with pharmacological treatments. Several behavioral methods were explored, including Aversive conditioning, which, along with CBT, has shown success in clinical trials. Techniques such as cue exposure, contingency management, community reinforcement, coping skills, and relapse prevention are among the key strategies employed by clinicians. These techniques, grounded in the principles of CBT, aim to enhance motivation and coping skills in individuals struggling with alcohol consumption.
57. Olthuis, Watt, Mackinnon, and Stewart (2015)[123] emphasize Cognitive Behavioral Therapy (CBT) for individuals with high anxiety sensitivity (AS), a trait associated with increased alcohol consumption and related problems. AS is also linked to heightened sensitivity to the anxiety-reducing effects of alcohol and stronger motives for drinking to alleviate negative emotions. The study investigates the effects of a telephone-delivered CBT program targeting high AS on alcohol-related outcomes. Eighty participants seeking treatment for AS-related concerns were randomly assigned to either an eight-week telephone CBT program or a waiting list control. Measures of drinking motives and problem drinking were administered before and after treatment. The findings suggest that

an AS-targeted intervention could potentially reduce risky alcohol use cognitions and behaviors. However, further research is warranted, particularly with a sample of individuals experiencing problem drinking.

58. Ness, M. L., & Oei, T. P. S. (2005)[124] conducted a study examining the Inpatient Group Cognitive Behavioral Therapy Program for Alcohol Dependence. The study included 37 male and 34 female participants diagnosed with alcohol dependence. Patients engaged in 42 CBT sessions spread over three weeks, each lasting one hour. Daily monitoring of group attendance rates was performed. Additionally, two structured phone calls were conducted at one month and three months post-discharge. The findings revealed that attendance rates at CBT group sessions did not correlate with improvements observed at the end of therapy or with drinking behaviors at the three-month follow-up. The study did not fully support the effectiveness of group CBT and cognitive models in addressing problem drinking.
59. Coates, J. M., Gullo, M. J., Feeney, G. F. X., Young, R. M., & Connor, J. P. (2018)[125] conducted a randomized trial evaluating Cognitive Behavioral Therapy (CBT) for alcohol use disorder within a Public Health clinic setting. The study enrolled 379 participants, who were randomly assigned to treatment modules focused on craving, positive expectancy, or impulsivity based on their assessment results. Treatment consisted of eight one-hour sessions of CBT delivered by clinical psychologists over 12 weeks. On average, patients attended 4.4 sessions, with 93 individuals (25%) completing the entire 12-week treatment course. The mean proportion of drinking days between sessions was 5% which showed an average consumption of 64 grams of ethanol. However, no significant effects of the targeted treatments were observed on drinking days or consumption. The study concluded that within a public health service context, the efficacy of individualized treatment addressing identified risk mechanisms from pre-treatment assessments was not

established. Nonetheless, some evidence suggested an enhanced treatment response with the implementation of a manualized craving module, particularly for individuals with high pre-treatment craving levels.

60. Berking, M., Margraf, M., Ebert, D., Wupperman, P., Hofmann, S. G., & Junghanns, K. (2011)[126] conducted a study titled "Deficits in Emotion-Regulation Skills Predict Alcohol Use During and After Cognitive–Behavioral Therapy for Alcohol Dependence" to explore whether deficiencies in adaptive emotion-regulation skills contribute to alcohol dependence (AD). The research involved 16 individuals undergoing cognitive–behavioral therapy for AD. Emotion regulation and the severity of AD symptoms were evaluated through self-report measures. Alcohol consumption during treatment was monitored using Breathalyzer and urine analysis for ethyl glucuronide, while self-reports were used to assess alcohol use during the 3-month follow-up period. The study found that pre-treatment emotion-regulation skills were predictive of alcohol use during treatment, and post-treatment emotion-regulation skills were predictive of alcohol use during follow-up, even when accounting for other factors potentially related to emotion regulation. Among various specific emotion-regulation skills, the capacity to tolerate negative emotions was the sole skill that inversely predicted subsequent alcohol consumption, even after controlling for other skills. Individuals in the AD group reported significantly greater deficits in emotion-regulation skills. Therefore, the results suggest that improving general emotion regulation skills, particularly the ability to cope with negative emotions, is crucial in the treatment of AD.
61. Hussin and colleagues (202)[127] investigate the impact of two distinct modes of Cognitive Behavioral Therapy (CBT) - Standard CBT (CBT(S)) and Brief CBT (CBT(B)) - on LOC among individuals with substance abuse issues. Using a quasi-experimental design with two treatment groups and one control group, the researchers aimed to assess how these interventions affected the LOC among 108 drug abusers. Employing repeated measurements across four time

points, the study found significant variations in LOC mean scores among the CBT(S), CBT(B), and control groups. Notably, both CBT(S) and CBT(B) interventions were shown to significantly enhance LOC among drug abusers, indicating the effectiveness of these therapeutic methods in empowering individuals to feel more in control of their lives. This study provides results on the advantages of CBT in addressing cognitive and behavioral aspects linked to substance abuse, highlighting the importance of psychological interventions in assisting individuals on their path to recovery from drug addiction.

62. The paper authored by Samoilov and Goldfried (2000)[128] delves into the significance of emotion within cognitive-behavior therapy (CBT), suggesting that to bolster its long-term efficacy, CBT should extend its focus beyond cognitive symptoms to encompass underlying emotional significance. Synthesizing insights from cognitive science, experimental psychology, and cognitive neuroscience, the authors emphasize the differentiation between cognitive and emotional realms of information processing. They contend that integrating emotional processing into CBT can yield more profound therapeutic results by tackling implicit emotional meanings that may underlie cognitive distortions and maladaptive behaviors. By incorporating affective processes into therapy sessions, CBT practitioners can assist clients in reorganizing emotional significance, thus facilitating clinical progress. This article contributes to advancing comprehension of how emotions impact cognitive-behavioral interventions and emphasizes the necessity of addressing emotional aspects to enhance CBT's effectiveness.
63. A study by Abas Solaimani Khashab and colleagues (2017)[129] examined how cognitive behavioral therapy (CBT) impacts the spiritual well-being and emotional intelligence of elderly mourners. Conducted in Ardabil, Iran, the study utilized an experimental setup with pre-and post-test assessments, including a control group. Thirty elderly mourners were selected through clinical interviews

and diagnostic tests. Data collection involved administering the Spiritual Well-Being questionnaire and the Emotional Intelligence questionnaire. The findings indicated that CBT significantly enhanced both spiritual well-being and emotional intelligence in the participants. Notably, there were no notable differences between the intervention and control groups, suggesting CBT's efficacy irrespective of group assignment. Furthermore, no significant variations in spiritual well-being and emotional intelligence were observed between the groups initially. These results underscore CBT's effectiveness in alleviating emotional distress and fostering grief acceptance, thereby boosting spiritual well-being and emotional intelligence among elderly individuals dealing with loss.

MATERIALS AND METHODS

SOURCE OF DATA

The study will be conducted on 40 patients diagnosed with substance use disorder(alcohol), as per ICD 10 criteria admitted in the psychiatry ward or visiting de-addiction OPD at Dayanand Medical College and Hospital, Ludhiana**.**

SAMPLE COLLECTION

The study included 40 male patients diagnosed with alcohol use disorder admitted to the psychiatric ward, or visiting psychiatric OPD at Dayanand Medical College and Hospital, Ludhiana within the age range of 18- 60 years.

RESEARCH DESIGN

Pre- and post-design was used for the current study. Participants underwent a pre-test, then received treatment intervention, followed by a post-test administered at the end of the intervention.

SAMPLING TYPE

A purposive sampling design was used to form a sample for data collection. Sample size estimation was used to ascertain the number of participants required for the study. Purposive sampling involved deliberately selecting specific participants who met the inclusion criteria relevant to the research questions. The inclusion and exclusion criteria used for the present study were as described below:

INCLUSION CRITERIA

- ICD 10 diagnosis of substance use disorder (alcohol)
- Undergoing pharmacological treatment and in the maintenance phase of treatment.
- Age range between 18 and 60 years
- Either gender
- Primary level education
- Time since diagnosis >1 years.
- Patient willing to give informed consent

EXCLUSION CRITERIA

- Patients with any other comorbid psychiatric disorder
- Major neurological disorder or communication disorder
- History of intellectual disability
- History of any other substance use except tobacco.

TOOLS FOR ASSESSMENT:

1. Socio-demographic Performa
2. Emotional intelligence Inventory:
3. Rotter's Locus of Control Scale
4. Multidimensional Scale of Perceived Social Support

DESCRIPTION OF THE TOOLS:

1. SOCIO DEMOGRAPHIC PERFORMA (Kuppuswamy, 2023)[130] containing identification details like age, gender, MRD number, occupation, education, and income, as well as the education and employment level of the head of the family was administered. Information was also gathered regarding the patient's current phase of illness and treatment modality. An informed consent form was used to ensure that all participants fully understood the purpose, procedure, potential risks, and benefits of the study before providing their consent. The form was also created in a regional language (Hindi and Punjabi) that the patients were well versed in as the present study involved participants who may not be fluent in the primary language of the consent form, i.e. English.

2. Rotter's Locus of Control Scale[131]**:** The Rotter Locus of Control Scale, created by Julian B. Rotter in 1966, evaluates how individuals perceive control over their lives. It's based on Rotter's theory that people attribute control to either internal or external forces. Respondents rate statements using a Likert scale, indicating agreement or disagreement. The scale covers various life circumstances and assesses reliance on factors like destiny or others' influence. Higher scores suggest confidence in internal control, while lower scores indicate reliance on external factors. Psychologists use it to understand behavior, decision-making, and well-being. The scale

consists of 29 statement pairs, with respondents choosing the option that best reflects their view. Scores range from 0 to 1, with lower scores indicating internal control and higher scores indicating external control

3. Emotional Intelligence Inventory[132]

Dr. S.K. Mangal created the Emotional Intelligence Inventory in 2015. It has 100 items in four primary categories: Intra-personal awareness, Interpersonal Awareness, Intra-personal Management, and Interpersonal Management. There is a methodical approach taken in doing the examination. Participants are required to respond" 2,1,o" and 'always, sometimes, never" to each item to indicate whether they agree or disagree with the statement made. Better scores suggest a better level of skill in that particular emotional intelligence category. The survey's scoring system, which provides a quantifiable evaluation of an individual's emotional intelligence across multiple areas, makes interpretation and analysis easier. The inventory is a useful tool for gathering information about people's abilities to comprehend and regulate their emotions, both in groups and individually. In-depth psychometric testing and validation processes have also demonstrated the validity and reliability of the inventory, ensuring its accuracy and effectiveness in assessing emotional intelligence competencies. It is intended for use by people who are at least 16 years old and who know Hindi and English. With a relatively straightforward scoring system that assigns one point for emotional intelligence present and zero for absence, this self-administering assessment is scored. The test's score range is as follows: 170–187 is high; 151–169 is above average; 126–150 is medium; 107–125 is below average; 89–106 is low; and 88 or lower is extremely low.

4. **Multidimensional Scale of Perceived Social Support**[132]**:** The Multidimensional Scale of Perceived Social Support (MSPSS) is a widely-used self-report tool developed in 1988 by Zimet, Dahlem, Zimet, and Farley to assess perceived social support across three main areas: family, friends, and significant others. Comprising 12 items, the

MSPSS allocates four questions to each of its three subscales. Respondents rate each item on a 7-point Likert scale, ranging from "very strongly disagree" to "very strongly agree." The mean score for each subscale is calculated by summing up responses and dividing by the number of items in that subscale. Scores on each subscale range from 1 to 7, with higher scores indicating greater perceived social support from the specific source. For example, a higher score on the family support subscale suggests stronger perceived support from family members. Conversely, lower scores may indicate dissatisfaction or a perceived lack of support from that particular source. The total scale score is obtained by adding together all 12 items and then dividing by 12. Mean total scale scores ranging from 1 to 2.9 could be considered low support, scores of 3 to 5 could be categorized as moderate support, and scores from 5.1 to 7 could be considered indicative of high support.

PROCEDURE

The study was conducted on 40 patients from 18 to 60 years of age, male and female, diagnosed with Substance Use Disorder and admitted to the Psychiatry Ward at Dayanand Medical College, Ludhiana undergoing deaddiction treatment. All participants were informed of the study's aims and objectives, as well as the fact that their participation was entirely voluntary. Every participant provided their informed consent.

They were informed that they had the option to withdraw from the study at any moment. No one was compelled or forced to take part in the study. They were informed that their identities would not be revealed, and confidentiality was discussed. They were informed of their right to ask questions at any point during the research They were also informed of their right to obtain a briefing on the study's findings if they so requested. Socio-Demographic Proforma was filed containing the basic information of the subject. They were evaluated for Emotional intelligence using the Emotional Intelligence Inventory, internal and E-LOC using Rotter’s Locus of Control Scale, and Social Support using the Multidimensional Scale of Perceived Social Support, All the tools

were clinician-rated. Each participant underwent seven weekly sessions of Cognitive Behavioural Therapy (CBT). The duration of the CBT sessions ranged from 30-40 minutes each. The CBT sessions were delivered via individual therapy. After completion of the 8TH CBT session, participants were reevaluated for Emotional intelligence, internal and E-LOC, and Social Support using the above-mentioned tools. After 4 weeks of the post-test, to evaluate the durability of the treatment, participants were re-evaluated to determine the effect of the therapeutic intervention in the follow-up phase on the above-mentioned tools. Scores were compared and analysed using appropriate statistical methods.

COGNITIVE BEHAVIOUR THERAPY:-

Cognitive Behavioral Therapy (CBT) is a proven approach for treating Alcohol Use Disorder (AUD) by addressing maladaptive thoughts, behaviors, and coping mechanisms. Through psychoeducation, goal-setting, and functional analysis of drinking behavior, clients gain insight into their alcohol use patterns. Cognitive restructuring techniques challenge irrational beliefs about alcohol, while behavioral skills training equips clients with coping strategies for managing cravings and urges. Lifestyle modification, social support enhancement, and relapse prevention strategies are integral components of CBT, promoting long-term recovery. By integrating evidence-based practices, CBT empowers individuals to make lasting changes in their relationship with alcohol, leading to improved well-being and reduced risk of relapse

CBT INTERVENTION PROCEDURE

In the current study, the researcher conducted 8 CBT sessions based on the mentioned 10 core principles. According to this therapeutic approach, people who use substances have inadequate coping mechanisms and apply conditional and traditional learning processes which makes them more susceptible to addiction. CBT should be applied collaboratively, in a warm manner, and based on a treatment relationship. It helps the participants build better resilience coping

strategies and hope for the future thereby reducing chances of substance relapse. Each session involved the use of relaxation exercises along with teaching effective problem-solving skills to the participants. An introductory session was followed by 8 CBT sessions (each session focusing on the CBT model's core for 30-45 minutes), lasting about components. A post-test session was conducted and Core concepts discussed during each session were rediscussed and strengthened throughout subsequent CBT sessions. The data was initially collected from 43 participants. However, 3 participants dropped out of the study as their number of CBT sessions could not be completed due to early discharge. The remaining 40 participants were retained in the study.

Intervention is derived from the Cognitive-Behavioral Therapy Book and Behavior Therapy Book;

Session Phase	**Description**
PRE-TEST PHASE	- Introductory session: Explanation of study aims and objectives, obtaining informed consent, and assurance of voluntary participation.
	- Detailed case histories taken, including substance use patterns, treatment history, and family substance use history.
	- Evaluation using assessments: Emotional Intelligence Inventory, Rotter's Locus of Control Scale, and Multidimensional Scale of Perceived Social Support.
SESSION 1	- Rapport formation and reflective listening.
	- Psychoeducation on Alcohol Use Disorder (AUD) and the Cognitive Behavioral Therapy (CBT) model of addiction.
	- Education on emotional intelligence (EI) and the

Session Phase	Description
	significance of social support in recovery.
	- Exploration of locus of control beliefs.
	- Introduction of self-monitoring activity and homework assignments (daily journaling, mindfulness exercises).
SESSION 2	- Review and reinforcement of previous session topics.
	- Introduction of the ABC model to understand substance use triggers and behaviors.
	- Encouragement of daily exercise as part of routine.
	- Homework assignments (daily mindfulness exercises, thought monitoring).
SESSION 3	- Exploration of emotions and strategies for emotional regulation.
	- Introduction of thought record sheet and challenging of unhelpful thoughts.
	- Teaching progressive muscle relaxation techniques.
	- Role-play of assertive communication and empathy scenarios.
	- Homework assignments (daily mindfulness exercises, emotion regulation techniques, assertive communication practice).
SESSION 4	- Bridging session to reinforce previous topics.
	- Assessment of social support networks and barriers.
	- Teaching assertiveness skills for maintaining supportive relationships.

Session Phase	Description
	- Introduction of behavioral activation techniques.
	- Homework assignments (progressive muscle relaxation planning, behavioral activation).
SESSION 5	- Identification and challenging of cognitive distortions related to substance use.
	- Introduction of Socratic questioning and cognitive restructuring techniques.
	- Homework assignments (thought challenging exercises, assertiveness skills practice).
SESSION 6	- Targeting negative cognitive distortions and core beliefs.
	- Continued practice of Socratic questioning and cognitive restructuring.
	- Introduction of stimulus control and sleep hygiene techniques.
	- Homework assignments (thought challenging exercises, stimulus control practice).
SESSION 7	- Reflection on changes in locus of control, emotional intelligence, and social support.
	- Introduction of adaptive problem-solving and conflict-resolution strategies.
	- Focus on assertiveness training and its significance in daily life.
	- Homework assignments (assertiveness scenario recall, problem-solving practice).
SESSION 8	- Review of treatment progress and challenges.
	- Discussion of setback management and future strategies.

Session Phase	Description
	- Preparation for post-therapy and closure.
	- Reevaluation of locus of control, emotional intelligence, and perceived social support.
	- Participants were thanked for their participation and informed about accessing study results.

SESSION PLAN:

PRE-TEST PHASE-

- **INTRODUCTORY SESSION:** Participants were provided with an explanation of the study's aims and objectives.
- Informed consent was obtained from all participants.
- Participants were assured of the voluntary nature of their participation and their right to withdraw at any time.
- Information about the potential implications of the study and access to study results was provided.
- Participants were briefed on the active nature of the intervention to be administered.
- The researcher prioritized building rapport with the participants.
- Participants completed a socio-demographic proforma.
- Detailed case histories were taken, including substance use patterns, intake methods, withdrawal symptoms, treatment history, family substance use history, and other relevant factors
- They were further evaluated on assessments Emotional Intelligence Inventory, Rotter's Locus of Control Scale, and Multidimensional Scale of Perceived Social Support.

SESSION 1

The session started with rapport formation. Reflective listening was used to establish a rapport with the participants. The session was focused on getting to know about the participant's view about his illness, and its impact on his/her social, financial, and interpersonal life.

Psychoeducation

Psychoeducation entails informing individuals about the causes, symptoms, and consequences of Alcohol Use Disorder (AUD) while collaboratively establishing treatment goals focused on reducing alcohol consumption, enhancing coping skills, and promoting overall well-being. Emphasizing the CBT model of addiction, participants learn about the interplay between thoughts, emotions, behaviors, and physical reactions.

Additionally, we educate them about emotional intelligence (EI), which involves effectively recognizing and managing emotions to prevent triggers and alcohol use. By developing EI skills such as self-awareness, self-regulation, empathy, and interpersonal skills, individuals can cope with stressors, regulate emotions, and make healthier choices. Also, patients are educated on the significance of social support in recovery, understanding how a strong network of family, and friends. We encourage individuals to explore their LOC beliefs, distinguishing between external and internal LOC, which empowers them to take charge of their recovery journey. Shifting towards an internal LOC mindset fosters accountability, goal-setting, and positive changes conducive to sobriety.

Between-session activities

We introduced the Self-Monitoring activity with the rationale of Encouraging the individual to keep a daily record of their alcohol consumption, including the type and amount of alcohol consumed, triggers for drinking, and associated thoughts and feelings. This self-monitoring helps raise awareness of drinking patterns and triggers.

Homework: *Daily journaling to track thoughts, emotions, and social interactions related to substance use and well-being and mindfulness exercises*

SESSION 2

The patient's understanding of what was discussed in the previous session was checked in the bridging session, conducted for 5 minutes, and was reinforced using a bridging worksheet as an essential to the patient's progress made outside of the therapeutic alliance.

In this session, we introduce ABC MODEL with the rationale that individuals can gain insight into the underlying factors contributing to their substance use and begin to develop healthier coping strategies to manage their addiction. In ABC MODEL "A" stands for antecedents, which are the triggers or situations that precede substance use. Examples may include stress, boredom, peer pressure, or certain environments. B stands for behavior that influences an individual's reaction to antecedents. These behaviors may include thoughts like "I need alcohol to relax" or "I can't have fun without drinking." Lastly, "C" stands for consequences of substance use, both positive and negative. Positive consequences may include temporary relief from stress or anxiety, while negative consequences may include health problems, relationship issues, or legal troubles. Participants were encouraged to use exercise as part of their daily routine for 30 minutes daily.

Homework: Daily mindfulness exercises, Thought monitoring

SESSION 3

In this session, we Explore the nature of emotions, including their physiological and cognitive components. Teach strategies for recognizing and labeling emotions accurately. Assess the patient's current emotional awareness and regulation strategies. A seven-column Thought record was provided to challenge unhelpful thoughts and beliefs. Introducing the concept of thoughts and the first three columns of the thought record sheet (situation, automatic thoughts, emotions, and mood), practice the sheet using

one of the events of last week was focused upon. Once a hot thought and its accompanying emotion were identified and rated, the hot thought was questioned to generate evidence for and against it, And also Introduce emotion regulation techniques such as deep breathing, during the session we Identified irrational and distorted beliefs such as automatic negative thought related to alcohol use, such as "I need alcohol to cope under pressure" or "I can't enjoy myself without alcohol"

Teach progressive muscle relaxation techniques to enhance emotional self-awareness and regulation. Role-play scenarios to practice

assertive communication and empathy. **Assign homework**: *Daily mindfulness exercises, emotion regulation techniques, and practicing assertive communication in real-life situations*.

Session 4

The patient's understanding of what was discussed in the previous sessions was checked in the bridging session. Assess the patient's current social support network and identify strengths and gaps. Explore barriers to seeking and receiving social support. Teach assertiveness skills for initiating and maintaining supportive relationships. Role-play effective **communication and conflict resolution strategies.** Develop a plan for expanding social support networks and engaging in supportive activities. During the session "The last four columns of the thought record sheet": Evidence for and against thought, Alternative response, and New rating of emotion were introduced. Generation of alternative thought using evidence and the believability of alternative thought was rated. Re-rating of the emotion of hot thought was elicited by the generation of alternative thought. Behavioral skills developed would be further reinforced. Behavioral activation including a set of procedures and techniques aimed at increasing patient activity and access to reinforcing situations that improve his mood and functioning was emphasized along with its rationale. The re-introduction of pleasant events using behavioral activation along with reversing avoidance was highlighted. Active coping to decrease stress through accomplishment or overcoming avoidance would be focused upon. Activation was measured and documented in the form of the number, frequency, or duration of activities to track the progress.

***Homework assignment*:** *Planning for progressive muscle relaxation twice a day, and following behavioral activation.*

Session 5

In this session, identify and challenge cognitive distortions related to substance use and recovery. our main goal is to identify an Unhelpful thinking style using Socratic questioning. Socratic questioning involves asking a series of open-ended, brief questions that guide patients to discover their idiosyncratic thoughts, feelings, or behaviors associated

with a particular situation to expose the troubling ideas or beliefs so that they can be challenged.

Teach cognitive restructuring techniques to challenge irrational beliefs and negative thought patterns. Explore how cognitive distortions influence emotions and behavior. Practice reframing distorted thoughts and generating more balanced perspectives. Discuss strategies for maintaining cognitive flexibility and resilience. Discuss common triggers and high-risk situations for relapse. Develop a personalized relapse prevention plan with coping strategies for managing cravings and stressors.

Assign homework*: Thought challenging exercises and identifying cognitive distortions in daily life. ,. Initiating contact with supportive individuals, attending support group meetings, and practicing assertiveness skills*.

SESSION 6

Modification of negative cognitive distortions and attributions regarding health, emotions, and social support coping. Identification of patterns of cognitive distortions and targeting the core beliefs regarding health, emotions, and social support would be done. Try to challenge unhelpful thoughts or beliefs that the patient identified in his previous session with the help of Socratic questioning. Cognitive restructuring was done to challenge myths or unhelpful thinking styles associated with fear. Practice reframing distorted thoughts and generating more balanced perspectives. Discuss strategies for maintaining cognitive flexibility and resilience. Techniques of Stimulus control and Sleep restriction were highlighted and introduced as a part of sleep hygiene. *Homework: Thought challenging exercises and identifying cognitive distortions in daily life.*

Session 7.

Reflect on changes in LOC, emotional intelligence, and social support. Develop a plan for maintaining gains and preventing relapse in the long term. Introducing adaptive problem-solving skills and conflict-resolution strategies. Problem-solving techniques were introduced which included the identification of effective means of coping with problems to enable

patients to use the strategies after therapy ends. Techniques of analyzing the problem, identifying options for coping, evaluating the options, deciding upon a plan, and developing strategies for implementing the plan were suggested. Our main focus on Assertiveness training is to help individuals develop the skills and confidence to express their needs, feelings, and opinions effectively. Assertiveness training can help individuals overcome feelings of insecurity, build stronger relationships, and improve communication skills. describing the assertiveness program and its importance in daily life;

homework *assignments for remembering the situations in which the individual faced a challenge concerning assertiveness and the reaction he showed in that situation*

Session 8

Review progress and challenges encountered during treatment. Discuss strategies for managing setbacks and maintaining motivation. Review the patient's progress and achievements throughout therapy. last session focuses on self-preparation for the therapy and closing. Discuss strategies for managing future challenges and stressors. Establish a plan for follow-up and ongoing support post-therapy Generally, this session helps to prepare and set themselves to be ready for the rehabilitation

Post-test phase:

Post the completion of the 8th session, participants reevaluated LOC, emotional intelligence, and perceived social support. They were thanked for their active participation in the study. They were informed about their rights to obtain the results of the study, should they ask for it.

Follow-up phase:

Participants were informed about the *follow-up session* scheduled to take place after 4 weeks after the post-test phase. During this session, they were evaluated on the rotter LOC emotional intelligence inventory and Multidimensional Scale of Perceived Social Support to assess the efficiency of CBT by evaluating the durability of the treatment, and

outcomes of the intervention. Any doubts that they may have had through the study were cleared.

STATISTICAL ANALYSIS:

Comparison of pre and post-quantitative variables will be done using the Paired t-test and Wilcoxon Rank test for independent samples for parametric and non-parametric data respectively. All statistical calculations will be done using (Statistical Package for the Social Science) SPSS 21version (SPSS Inc., Chicago, IL, USA) statistical program for Microsoft Windows.

OBSERVATION AND RESULTS

1. Table: Mean Age Of Participants In Alcohol Use Disorder

AGE GROUP	N	MEAN	SD
25-34	9	42.6	7.13
35-44	15	42.6	6.86
45+	16	42.6	7.07

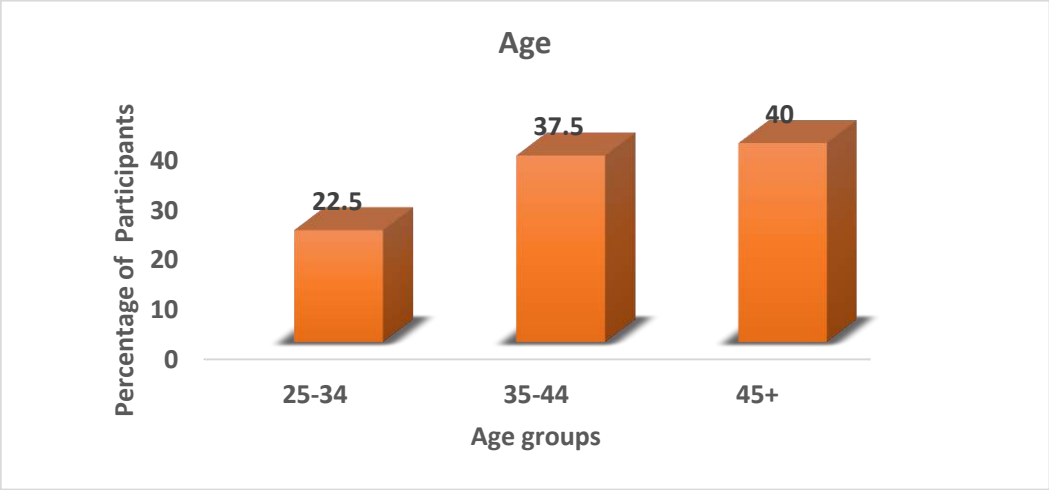

Figure 1: Mean Age Of Participants In Alcohol Use Disorder

The mean age of participants was 42.6 years (range: 26-60), highlighting the widespread impact of Alcohol Use Disorder across ages.

2. **Table: Distribution Of Educational Qualification In Alcohol Use Disorder**

Education	N	FREQUENCY	%
8TH GRADE	40	1	2.5
10TH GRADE	40	6	15.0
INTERMEDIATE	40	23	57.5
GRADUATE	40	7	17.5
POSTGRADUATE	40	3	7.5

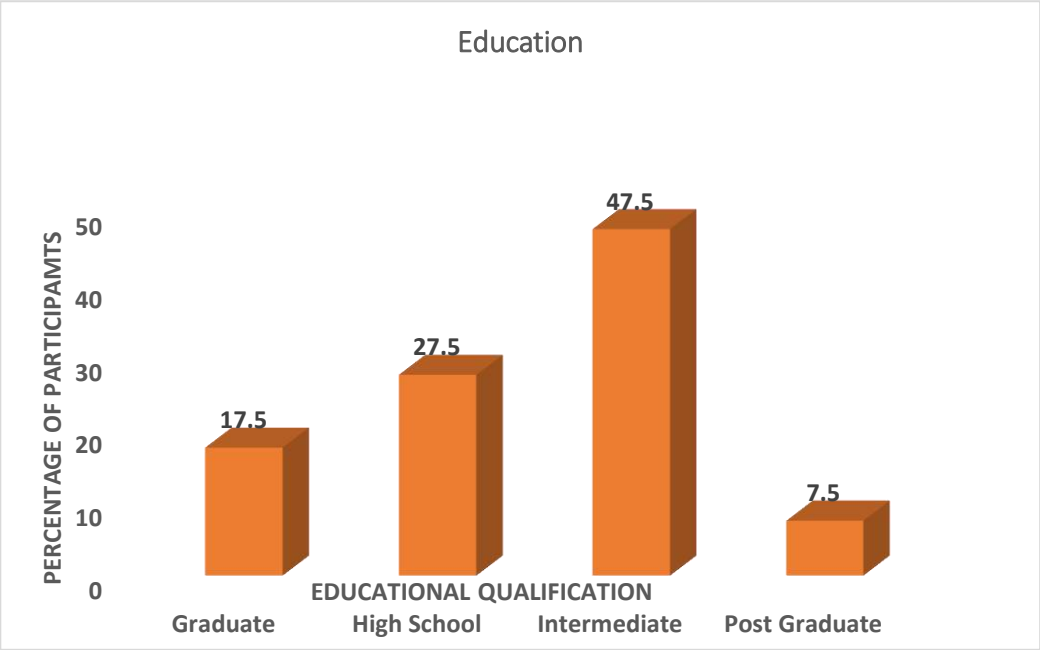

Figure 2: Distribution Of Educational Qualification In Alcohol Use Disorder

The majority of participants had intermediate-level education, comprising 57.5% of the sample, followed by 10th grade at 15.0%.

3. Table: Distribution of Occupation In Alcohol Use Disorder.

OCCUPATION	N	FREQUENCY	%
BUSINESSMAN	40	1	2.5
PROFESSIONAL	40	4	15.0
CLERK	40	1	2.5
FARMER	40	19	47.5
SEMI-SKILLED WORKER	40	4	10.0
SHOP-OWNER	40	3	7.5
UNEMPLOYED	40	1	2.5
OTHER	40	5	12.5

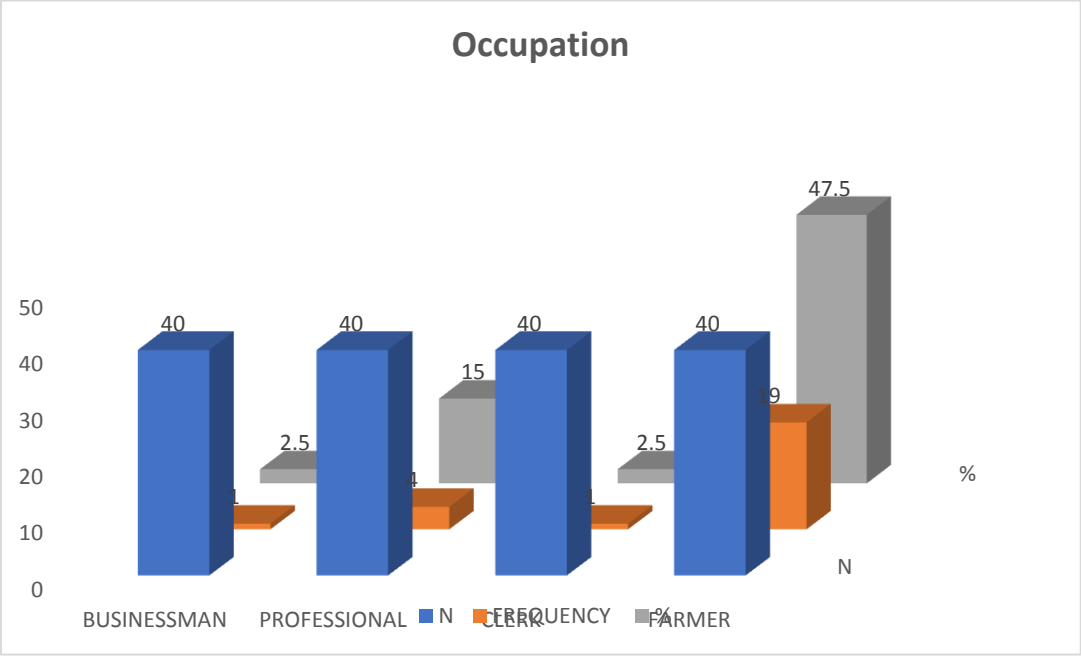

Figure 3: Distribution of Occupation In Alcohol Use Disorder.

Occupational diversity was observed; the highest frequency was among farmers (47.5%), and professionals (15%). Significance aligns with the literature on occupation's association with alcohol misuse.

4. Table: Distribution of family type In Alcohol Use Disorder.

FAMILY TYPE	N	FREQUENCY	%
JOINT	40	17	42.5
NUCLEAR	40	23	57.5

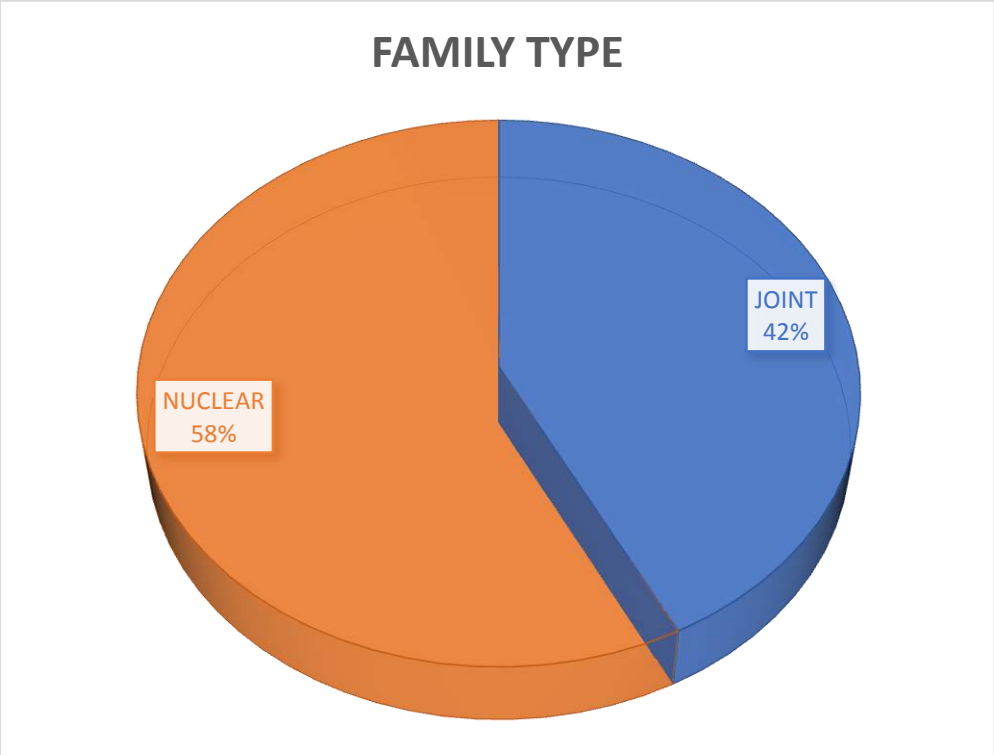

Figure 4: Distribution of family type In Alcohol Use Disorder.

Family distribution: 42.5% joint families, 57.5% nuclear families among AUD individuals. Significance indicates family structure's potential role in AUD.

5. Table: Distribution of area In Alcohol Use Disorder.

AREA	N	FREQUENCY	%
RURAL	40	19	47.5
URBAN	40	21	52.5

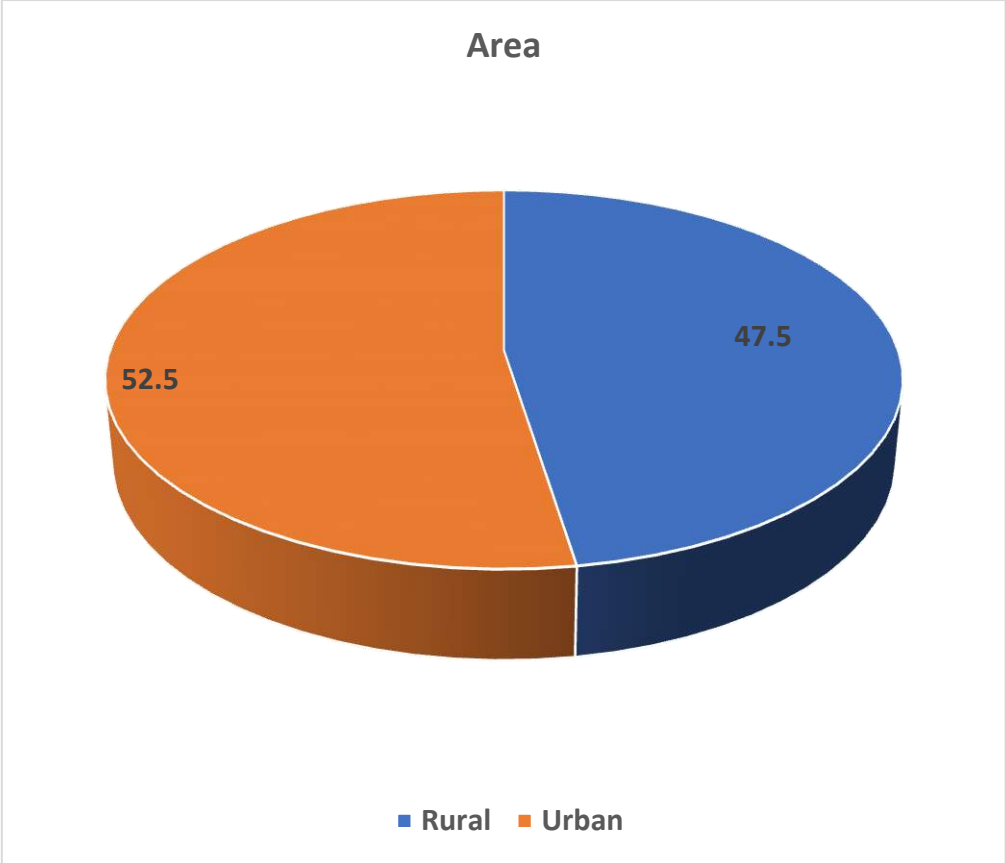

Figure 5: Distribution of area In Alcohol Use Disorder.

The table illustrates the distribution of individuals diagnosed with Alcohol Use Disorder (AUD) based on their area of residence, categorized into rural and urban areas. Among the total sample size of 40 individuals in each category, 19 individuals (47.5%) reside in rural areas, while 21 individuals (52.5%) reside in urban areas.

6. **Table: Distribution Of Socio-Economic Status In Alcohol Use Disorder.**

SOCIO-ECONOMIC STATUS	N	FREQUENCY	%
UPPER CLASS	40	1	2.5
UPPER MIDDLE CLASS	40	8	20.0
LOWER MIDDLE CLASS	40	28	70.0
UPPER LOWER CLASS	40	3	7.5

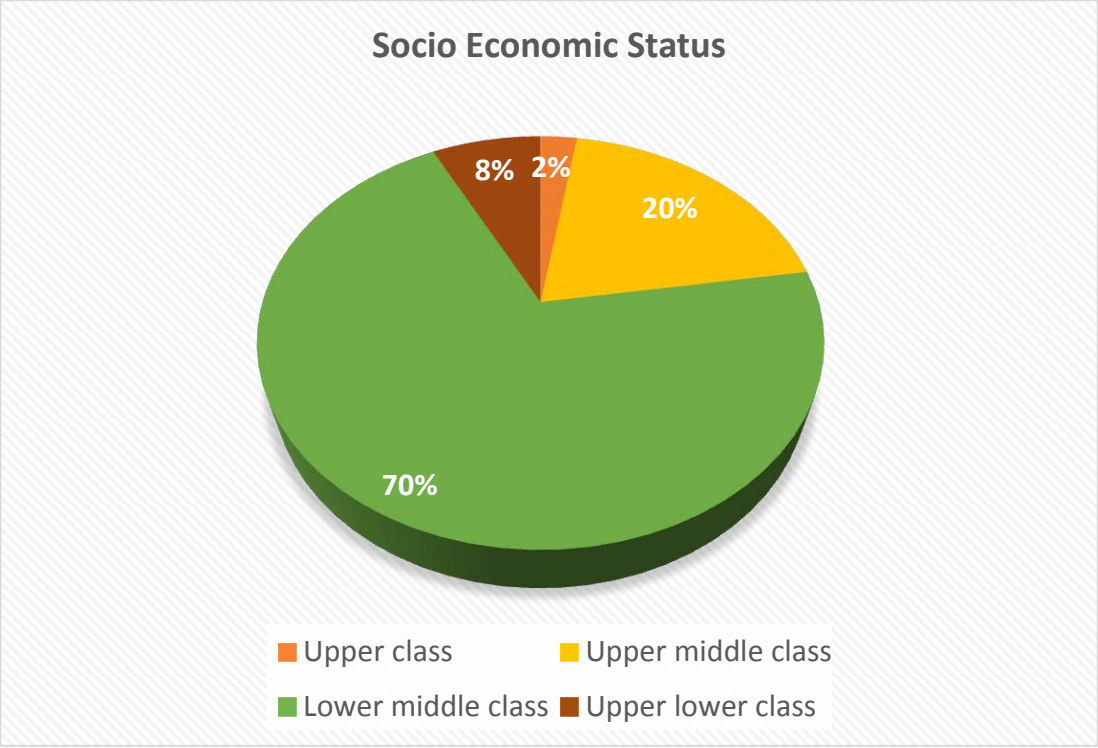

Figure 6: Distribution Of Socio-Economic Status In Alcohol Use Disorder.

Table 6. outlines the distribution of individuals diagnosed with Alcohol Use Disorder (AUD) by socio-economic status (SES), with 70% from the Lower Middle Class, 20% from the Upper Middle Class, and smaller percentages from the Upper Class (2.5%) and Upper Lower Class (7.5%).

7. Table. Correlation Between Pre-Locus Of Control, Emotional Intelligences, And Perceived Social Support.

Variable	N	Correlation coefficient	p-value
Pre-P.S.S, -pre LOC	40	0.0460	0.777
pre-EII & pre-P. S.S	40	0.0413	0.799
pre-EII & PRE-LOC	40	-0.109	0.502

*No significant associations were found between pre-LOC and pre-SS, pre-EII and pre-SS, or pre-EII and pre-LOC***.**

8. **Table. Comparison of pre and post-intervention scores on locus of control in alcohol use patients.**

LOCUS OF CONTROL	MEAN	SD	Z-SCORE	P-VALUE
PRE	11.98	3.423	-3.4+92	<0.001
POST	9.85	2.578		

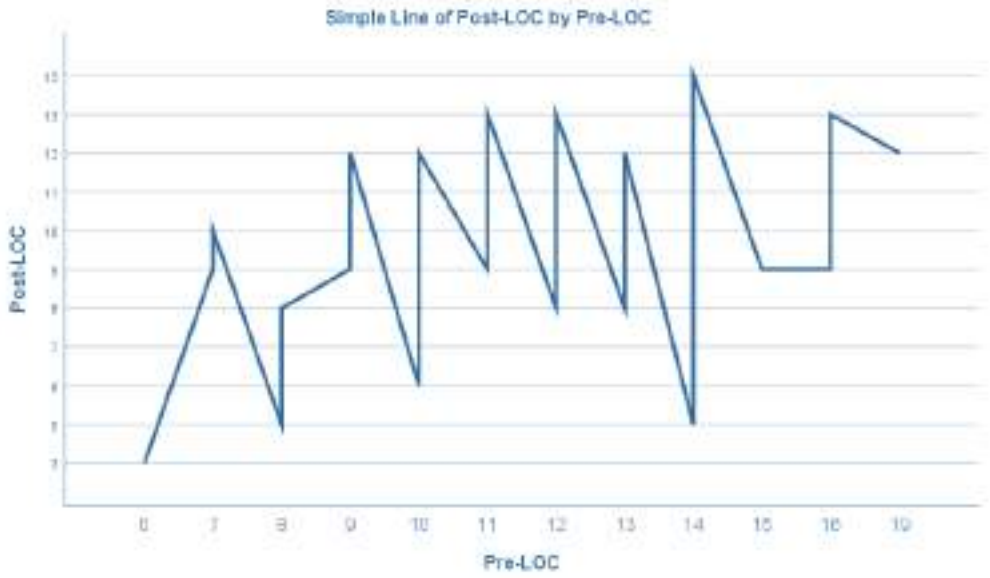

Figure 7: Comparison of pre and post-intervention scores on locus of control in alcohol use patients.

Pre-intervention: Mean 11.98, SD 3.423, Z-score -3.492, highly significant (p<0.001).

9. Table. Comparison of pre and post-intervention categories on locus of control in alcohol use patients.

Variable	Internal	External	Chi-square value	p-value
Pre	21	19	.358	.550
Post	35	5		

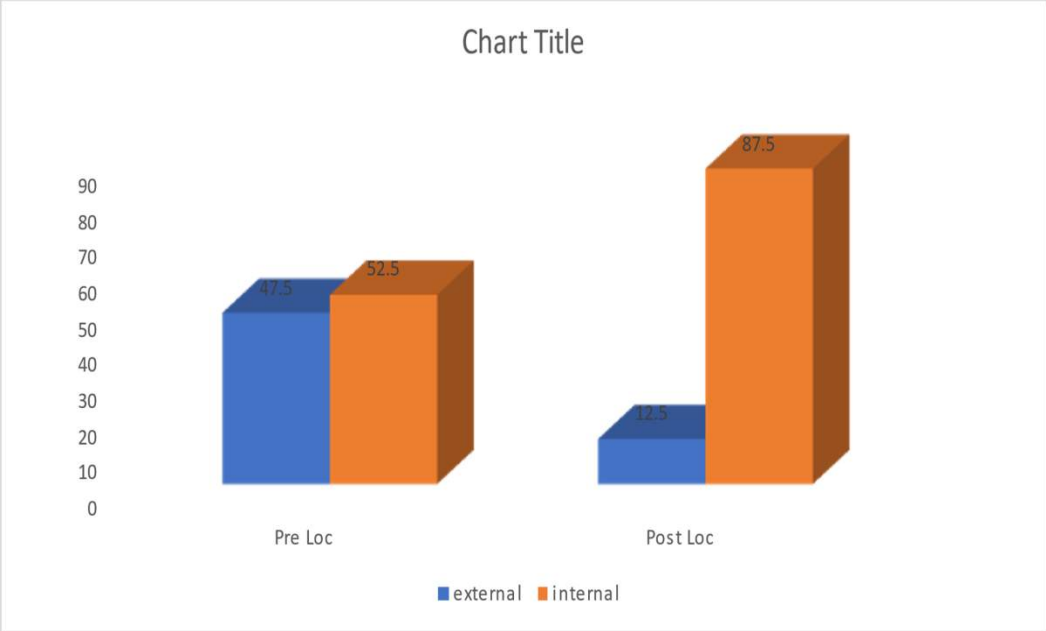

Figure 8: Comparison of pre and post-intervention categories on locus of control in alcohol use patients.

Post-intervention: Chi-square 0.358, p-value 0.550. Non-significant (p>0.05).

10. Table. Comparison of pre and post-intervention scores on Emotional intelligence in alcohol use patients.

EMOTIONAL INTELLIGENCE	MEAN	SD	Z-SCORE	P-VALUE
Pre	79.65	19.845	-5.499	.000
Post	109.35	24.388		

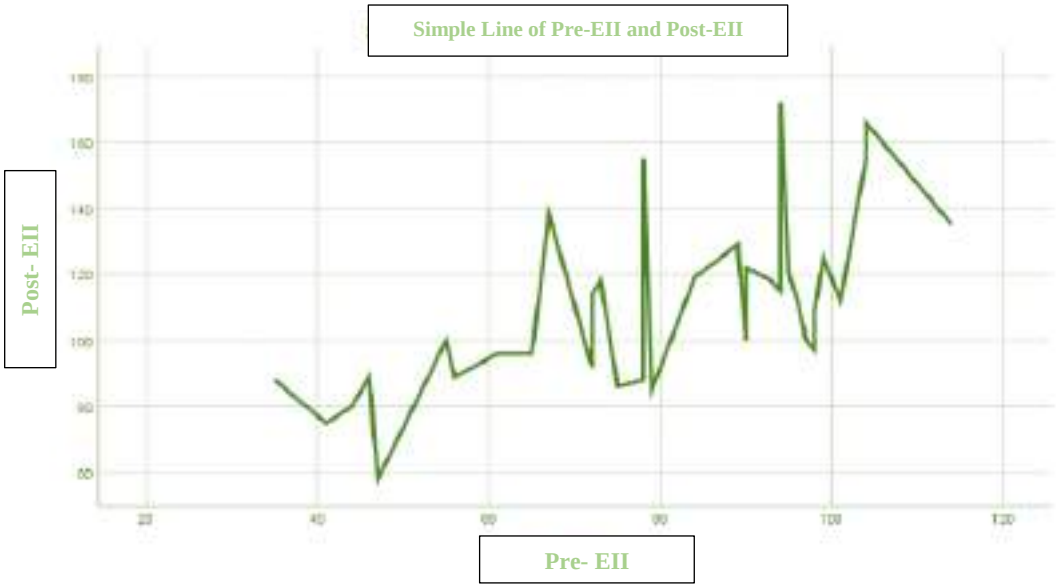

Figure 9: Comparison of pre and post-intervention scores on Emotional intelligence in alcohol use patients.

Post-intervention: Mean 109.35, SD 24.388, Z-score -5.499, highly significant improvement in emotional intelligence (p<0.001).

11. Table.Comparison of pre and post-intervention EQ on Emotional intelligence in alcohol use patients

Variable	Extremely low	Low	below average	average	Above average	high	Chi-square	p-value
Pre	**22**	**17**	**1**	**0**	**0**	**0**	13.339	.013
Post	**8**	**12**	**0**	**13**	**7**	**0**		

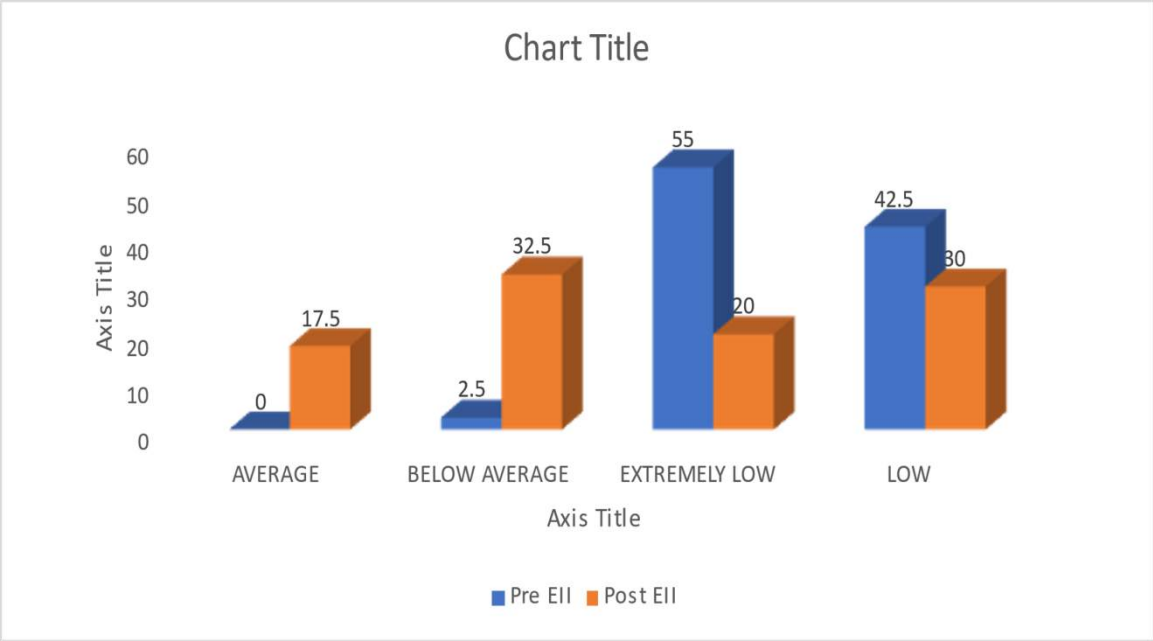

Figure 10: Comparison of pre and post-intervention EQ on Emotional intelligence in alcohol use patients

Post-intervention: Significant difference observed in emotional intelligence categories (p=0.013, Chi-square=13.339), indicating notable improvement in post-intervention emotional intelligence levels.

12. Table. Comparison of pre and post-intervention scores on perceived social support in alcohol use patients.

Perceived social support	Mean	SD	z-score	p-value
Pre	51.53	14.438	-5.245	.000
Post	63.60	12.598		

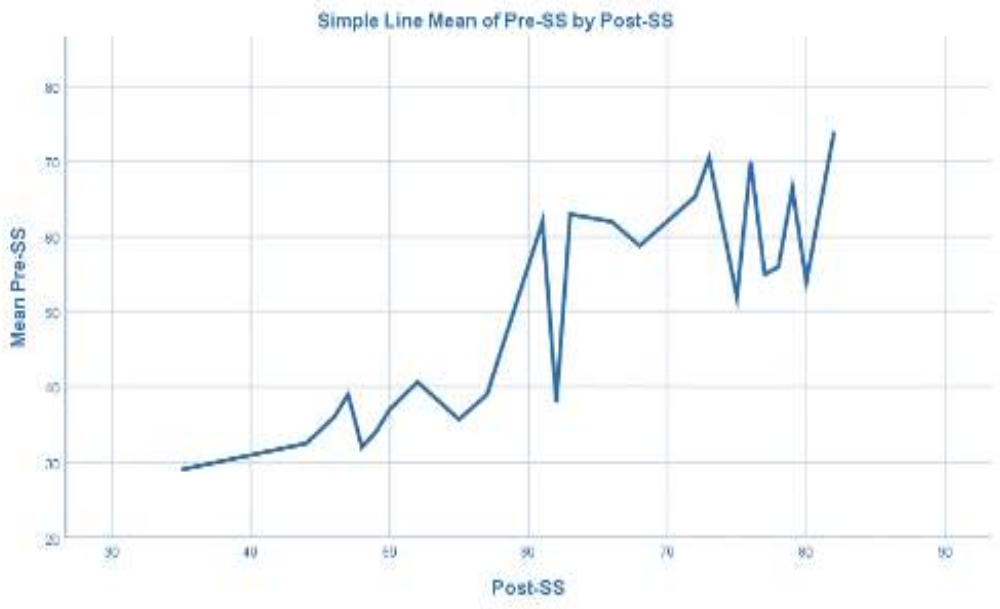

Figure 11: Comparison of pre and post-intervention scores on perceived social support in alcohol use patients.

Post-intervention: Mean 63.60, SD 12.598, Z-score -5.245, a highly significant increase in perceived social support (p<0.001).

13. Table. Comparison of pre and post-intervention categories on perceived social support in alcohol use patients.

Variable	Low	Moderate	high	Chi-square	p-value
Pre	**8**	**18**	**14**	20.106	.000
Post	**1**	**15**	**24**		

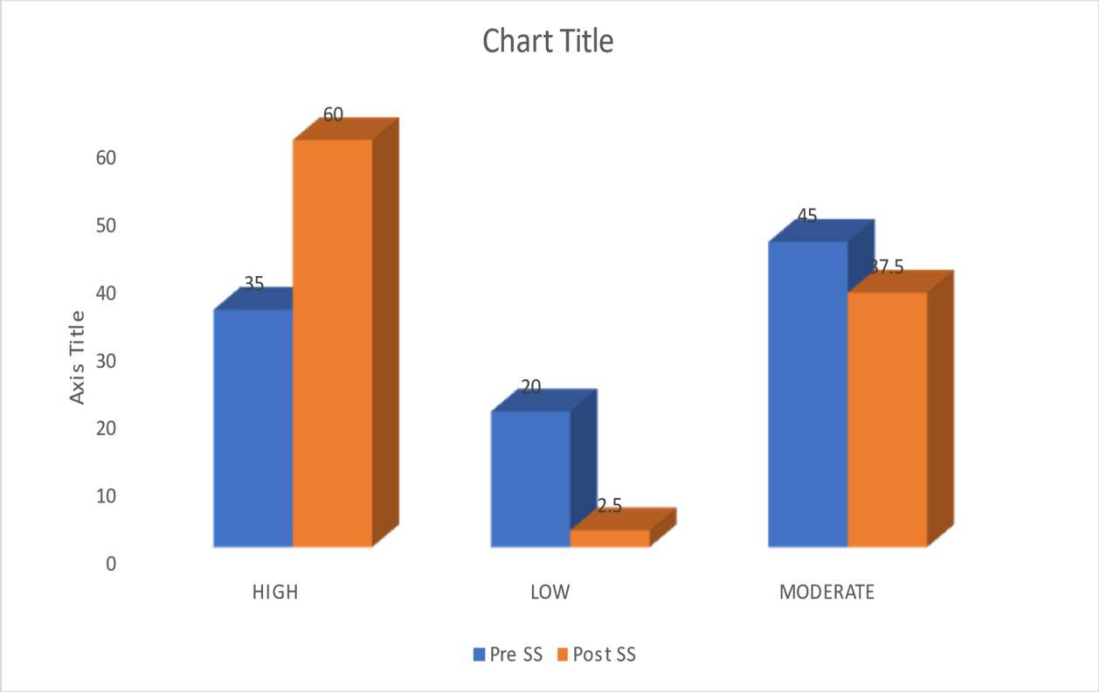

Figure 12: Comparison of pre and post-intervention categories on perceived social support in alcohol use patients.

Post-intervention: Chi-square 20.106, p<0.001. Significant differences were observed in a variable between pre-and post-intervention.

14. Table. Correlation Between POST-Locus Of Control, Emotional Intelligences, And Perceived Social Support.

Variable	N	Correlation coefficient	p-value
POST EII& POST P.S.S	**40**	**0.170**	**0.267**
POST-EII &POST LOC	**40**	**0.067**	**0.677**
POST-SS &POST LOC	**40**	**0.200**	**0.215**

Post-intervention correlations: Weak, non-significant for EII & PSS (p=0.267, r=0.170), EII & LOC (p=0.677, r=0.067), PSS & LOC (p=0.215, r=0.200).

15. Table. Comparison of post and follow-up -intervention scores on locus of control in alcohol use patients.

Locus of control	**Mean**	**Sd**	**DF**	**T-score**	p-value
Post	63.60	12.598	**39**		**.808**
Follow up	9.73	3.412	**39**	**.245**	

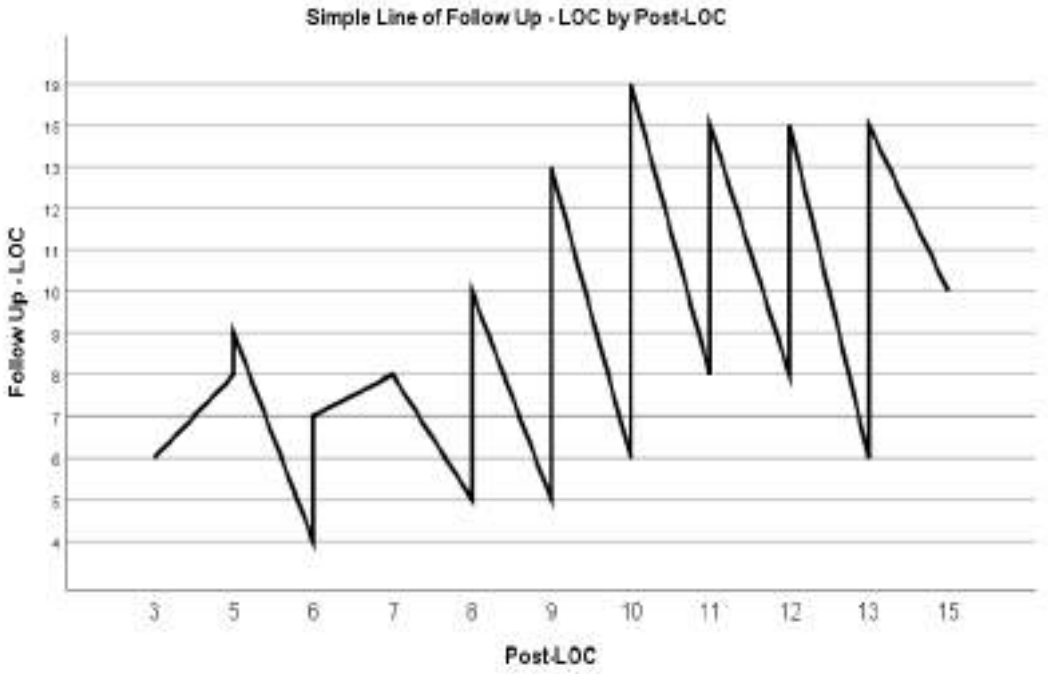

Figure 13: Comparison of post and follow-up -intervention scores on locus of control in alcohol use patients.

Post-intervention mean 63.60 (SD 12.598), and follow-up mean 9.73 (SD 3.412). No significant difference was observed (p=0.245, T=0.808).

16. Table. Comparison of post and follow-intervention categories on locus of control in alcohol use patients

Locus of control	internal	External	Chi-square	p-value
Post	21	19	.000	.743
Follow-up	08	32		

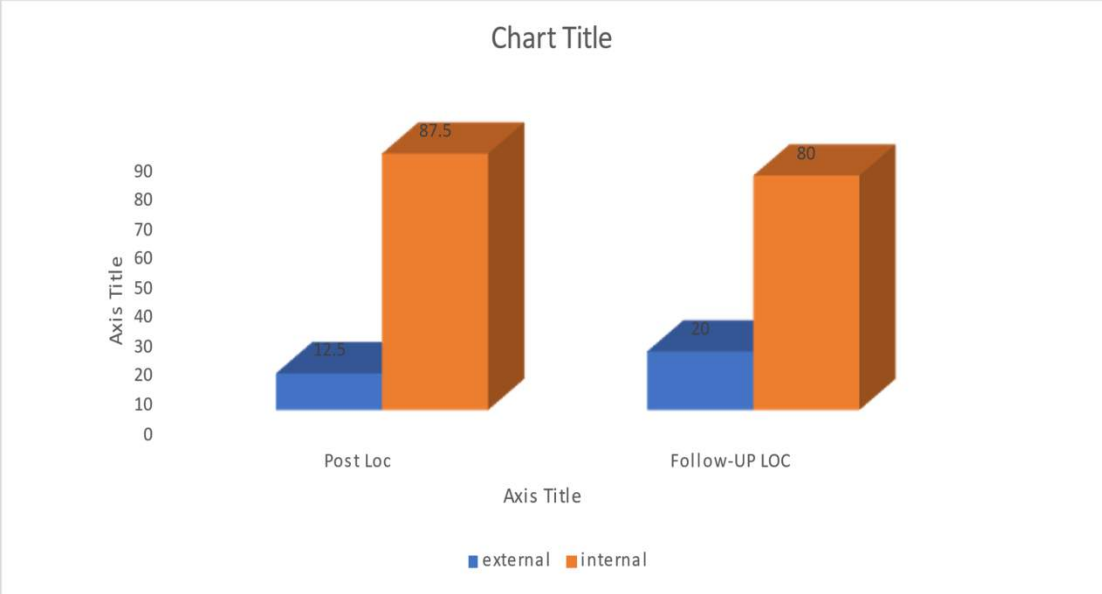

Figure 14: Comparison of post and follow-intervention categories on locus of control in alcohol use patients

Post: Internal 21, External 19. Follow-up: Internal 8, External 32. No significant difference was observed (p=0.743, Chi-square=0.000).

17. Table. Comparison of post and follow-up -intervention scores on Emotional intelligence in alcohol use patients

EMOTIONAL INTELLIGENCE	**Mean**	**Sd**	**DF**	**t- score**	p-value
Post	109.35	24.388	**39**	-1.478	
Follow up	111.57	21.259	**39**		.148

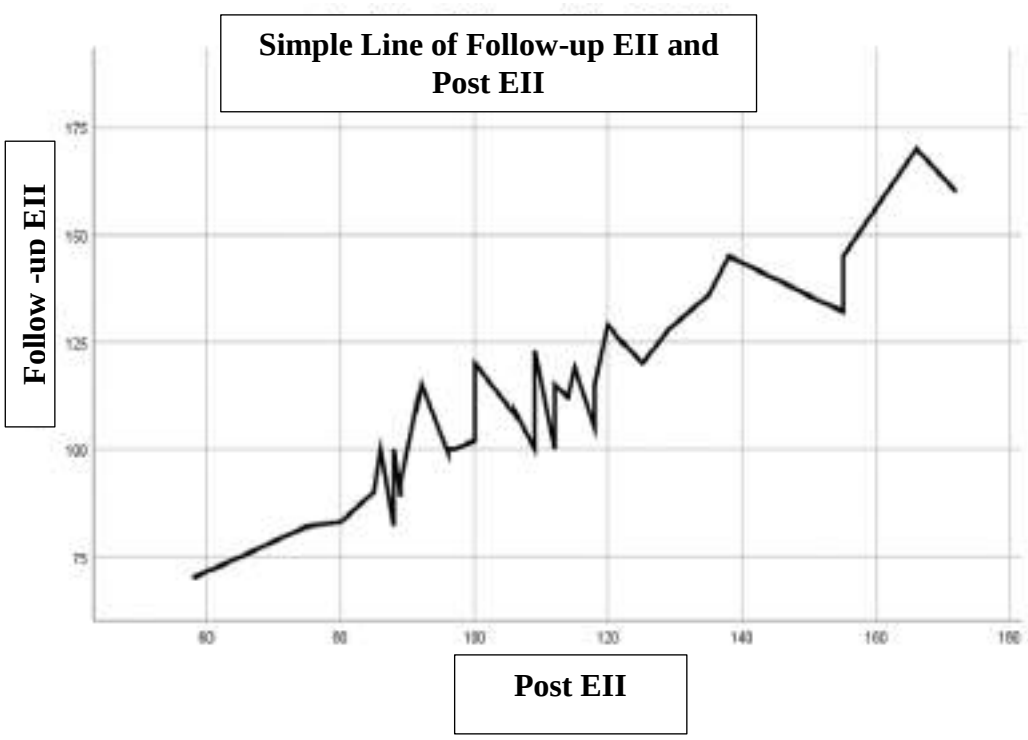

Figure 15: Comparison of post and follow-up -intervention scores on Emotional intelligence in alcohol use patients

Post: Mean 109.35 (SD 24.388). Follow-up: Mean 111.57 (SD 21.259). No significant difference was observed (p=0.148, t=-1.478).

18. Table.Comparison of post and follow -up-intervention EQ on Emotional intelligence in alcohol use patients

Variable	Extremely low	Low	below average	average	Above average	high	Chi-square	p-value
post	**8**	**12**	**13**	**7**	**0**	**0**	39.725	.000
Follow up	**4**	**14**	**14**	**6**	**1**	**1**		

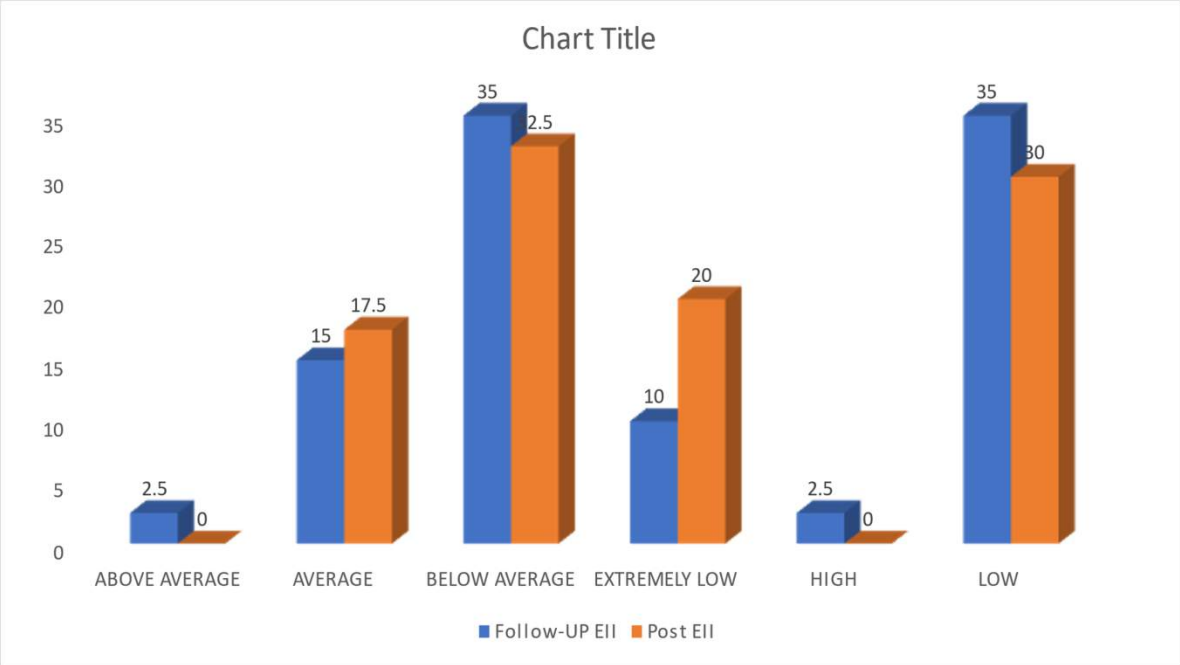

Figure 16: Comparison of post and follow -up-intervention EQ on Emotional intelligence in alcohol use patients

Post: Extremely low 8, Low 12, Below Average 13, Average 7. Follow-up: Significant difference observed (p<0.001, Chi-square=39.725).

19. **Table. Comparison of post and follow-up -and follow-up-intervention scores on perceived social support in alcohol use patients.**

SOCIAL SUPPORT	**Mean**	**Sd**	**DF**	**T- score**	p-value
Post	63.60	12.598	**39**	.530	.599
Follow up	64.30	13.041	**39**		

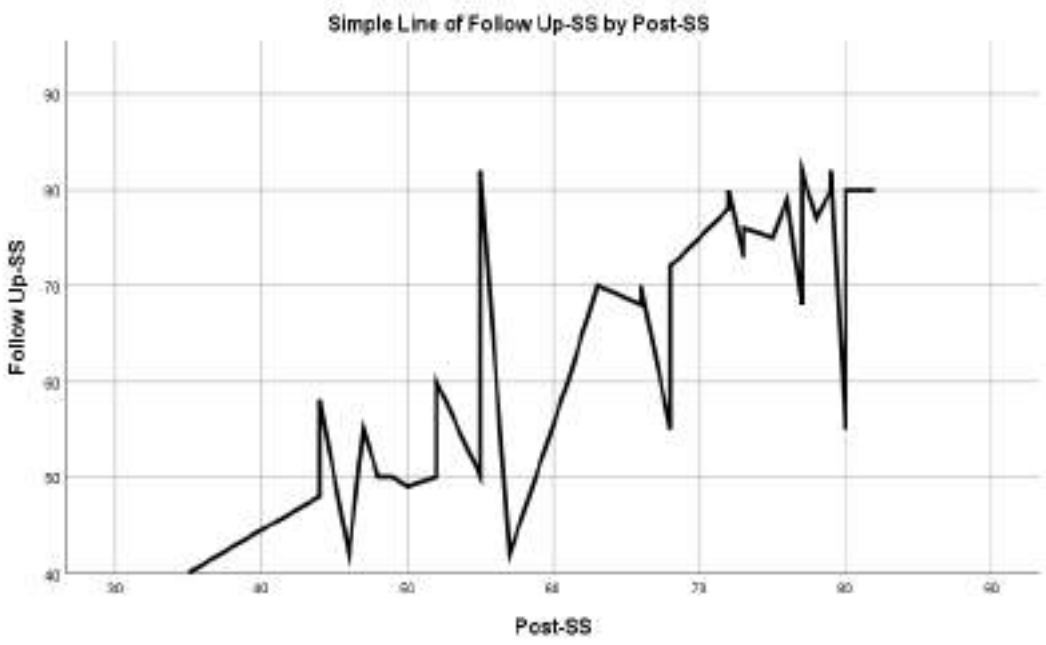

Figure 17: Comparison of post and follow-up -and follow-up-intervention scores on perceived social support in alcohol use patients.

Post: Mean 63.60 (SD 12.598). Follow-up: Mean 64.30 (SD 13.041). No significant difference was observed (p=0.599, T=0.530).

20. Table. Comparison of post and follow-up -intervention categories on perceived social support in alcohol use patients.

Variable	Low	Moderate	High	Chi-square	p-value
Post	**1**	**15**	**24**	24.148	.000
Follow up	**0**	**19**	**21**		

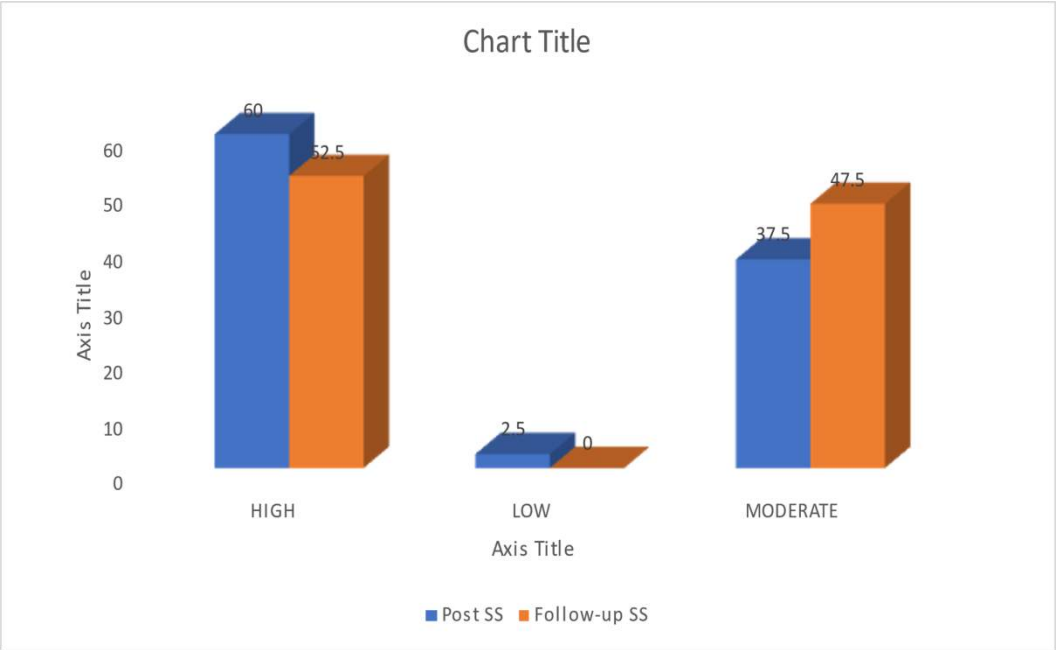

Figure 18: Comparison of post and follow-up -intervention categories on perceived social support in alcohol use patients.

Post: Low 15, Moderate 24, High 24. Follow-up: Low 0, Moderate 19, High 21. Significant difference observed (p<0.001, Chi-square=0.148).

21. Table. Correlation Between Follow-up -Locus Of Control, Emotional Intelligences, And Perceived Social Support.

Variable	N	Correlation coefficient	p-value
FOLLOW-UP EII&FOLLOW UP P.S.S	**40**	**0.041**	**0.799**
FOLLOW UP-EII &FOLLOW UP LOC	**40**	**0.155**	**0.338**
FOLLOW UP-SS & FOLLOW-UP LOC	**40**	**0.348**	**0.027**

Weak correlations were observed, except for a moderate positive correlation between follow-up perceived social support and locus of control (coefficient = 0.348, p = 0.027).

22. Table. Correlation Between pre and post-locus Of Control, Emotional Intelligence, And Perceived Social Support.

Variable	N	Correlation coefficient	p-value
Pre-LOC & post - LOC	40	.258	.108
pre-EII & post EII	40	.602**	.000
pre-P.SS & Post-P.S.S	40	.754**	.000

*Pre-LOC & post-LOC: Correlation 0.258, p-value 0.108.Pre-EII & post-EII: Correlation 0.602** (p<0.001).Pre-SS & post-SS: Correlation 0.754** (p<0.001).*

23. Table. Correlation Between post and follow up Locus Of Control, Emotional Intelligence, And Perceived Social Support.

Variable	N	Correlation coefficient	p-value
POST LOC & FOLLOW UP LOC	**40**	**0.258**	**.108**
POST-EII & FOLLOW UP-EII	**40**	**0.602**	**.000**
POST-SS &FOLLOW- UP -SS	**40**	**0.754**	**.000**

24. Table. Mean Comparison Of Pre, Post, And Follow-Up - Intervention Scores On Locus Of Control, Emotional Intelligence, And Perceived Social Support In Alcohol Use Patients

VARIABLE	Pre(mean)	Post(mean)	Follow-up(mean)
LOC	11.9	9.85	9.73
EII	79.65	109.35	111.58
P.S.S	51.53	63.60	64.30

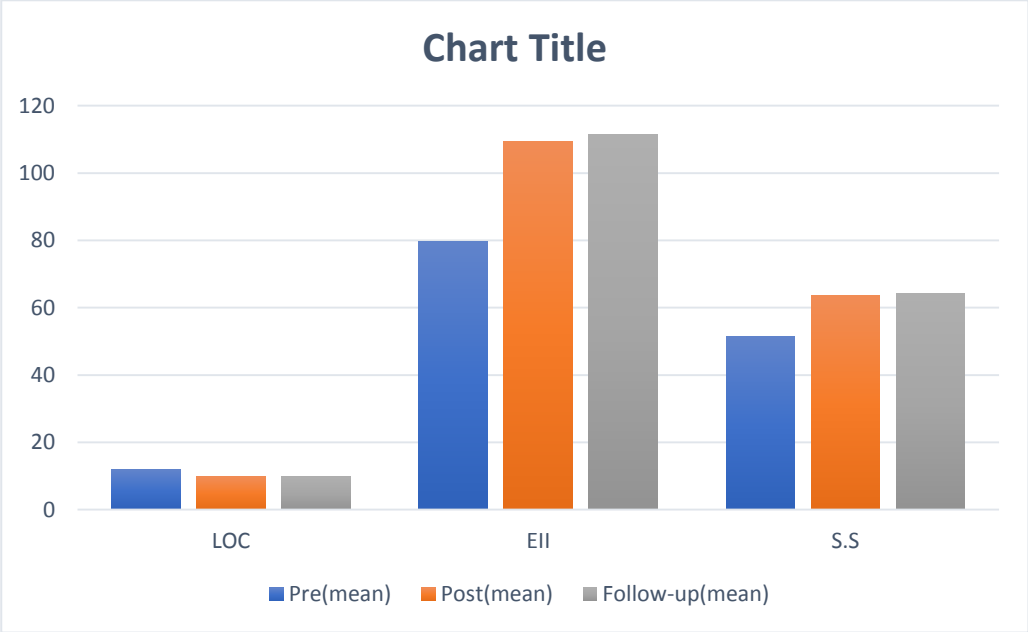

Figure 19: Mean Comparison Of Pre, Post, And Follow-Up - Intervention Scores On Locus Of Control, Emotional Intelligence, And Perceived Social Support In Alcohol Use Patients

Post-Follow-up:- LOC: Correlation 0.258, p-value 0.108.- EII: Correlation 0.602 ($p<0.001$).- SS: Correlation 0.754 ($p<0.001$).

RESULTS

1. Table. The results present data on the age distribution of participants in the study, with the participants grouped into three categories based on their age: 25-34, 35-44, and 45+. the mean age of participants is approximately 42.6 years. Additionally, the standard deviations indicate the degree of variability in age within each group. In this case, the standard deviations range from 6.86 to 7.13, suggesting a moderate level of variability in ages within the different age groups.
2. The table illustrates the educational distribution among individuals diagnosed with Alcohol Use Disorder (AUD). Among the 40 participants in each category, the majority (57.5%) have completed an intermediate level of education, indicating a prevalent educational status falling between basic and advanced levels. Additionally, 15% have achieved a 10th-grade education, while 17.5% hold graduate-level qualifications, and 7.5% possess postgraduate degrees. This diversity underscores the varied educational backgrounds within the AUD population, reflecting factors such as socioeconomic status and access to education. Understanding the educational profile of individuals with AUD is crucial for developing targeted interventions and support systems that address the complex interplay between education, substance use, and recovery.
3. Table. It categorizes participants into different occupational groups, such as businessmen, professionals, clerks, farmers, semi-skilled workers, shop owners, unemployed individuals, and others. The table presents the total number of participants (N) within each occupational category, the frequency of individuals falling into each group, and the corresponding percentage (%) relative to the total sample size of 40 participants. For instance, the highest frequency is observed among farmers, comprising 47.5% of the sample, followed by professionals at 15.0%. These findings shed light on the occupational backgrounds of individuals with AUD, highlighting the diversity within this population and providing valuable insights for

understanding the relationship between occupation and alcohol misuse.

4. Table illustrates the distribution of family types among individuals diagnosed with Alcohol Use Disorder (AUD). The two family types considered are joint families and nuclear families. Each row of the table represents a specific family type, while the columns provide information on the total number of participants (N), the frequency of individuals within each family type, and the percentage (%) relative to the total sample size of 40 participants. The data indicate that both joint and nuclear families are represented within the AUD population, with varying frequencies. Specifically, 42.5% of participants come from joint families, while 57.5% belong to nuclear families. These findings suggest that individuals with AUD are found across different family structures, highlighting the importance of understanding familial contexts in the assessment and treatment of AUD and emphasizing the need for tailored interventions that consider family dynamics.
5. Table presents the distribution of area types among individuals diagnosed with Alcohol Use Disorder (AUD). It categorizes participants into two distinct areas: rural and urban. Each row in the table represents one area type, while the columns provide information on the total number of participants (N), the frequency of individuals within each area type, and the corresponding percentage (%) relative to the total sample size of 40 participants. The data reveal that both rural and urban areas are represented within the AUD population, with differing frequencies. Specifically, 47.5% of participants reside in rural areas, while 52.5% are from urban areas. This indicates that individuals with AUD are found across diverse geographic locations, emphasizing the importance of considering environmental factors and contextual differences in understanding and addressing AUD. Additionally, it underscores the need for tailored interventions that account for the unique challenges and resources available in both rural and urban settings.

6. Table outlines the distribution of socioeconomic statuses among individuals diagnosed with Alcohol Use Disorder (AUD). It categorizes participants into four socio-economic classes: upper class, upper middle class, lower middle class, and upper lower class. Each row represents one socio-economic class, while the columns provide information on the total number of participants (N), the frequency of individuals within each socio-economic class, and the corresponding percentage (%) relative to the total sample size of 40 participants. The data reveal that the majority of participants (70.0%) belong to the lower middle class, followed by 20.0% in the upper middle class. Only a small percentage (2.5%) fall into the upper class, with a similar proportion (7.5%) in the upper lower class. This distribution suggests that individuals with AUD come from diverse socio-economic backgrounds, emphasizing the need for comprehensive interventions that address socio-economic factors alongside alcohol misuse.
7. Table displays the correlation coefficients and corresponding p-values between pre-locus of control (LOC), emotional intelligence (EII), and perceived social support (P.S.S) among the participants in the study. The correlation coefficients indicate the strength and direction of the relationships between these variables. For pre-locus of control and perceived social support (pre-P.S.S, -pre LOC), a very weak positive correlation of 0.0460 is observed, with a p-value of 0.777, suggesting that this correlation is not statistically significant. Similarly, the correlation between pre-emotional intelligence and perceived social support (pre-EII & pre-P.S.S) is also very weakly positive at 0.0413, with a non-significant p-value of 0.799. Furthermore, the correlation between pre-emotional intelligence and pre-locus of control (pre-EII & pre-LOC) is weakly negative at -0.109, but with a p-value of 0.502, indicating that this correlation is not statistically significant. Overall, the findings from Table 7 suggest that there are no significant correlations between pre-locus of control, emotional intelligence, and perceived social support among the study participants before the intervention.

8. Table compares the pre and post-intervention scores on Locus of Control (LOC) among patients with Alcohol Use Disorder (AUD). The mean pre-intervention LOC score is 11.98, with a standard deviation (SD) of 3.423, while the mean post-intervention LOC score is 9.85, with an SD of 2.578. A Z-score of -3.492 accompanies the pre-intervention score, indicating that it falls approximately 3.492 standard deviations below the mean. The corresponding p-value is less than 0.001, signifying statistical significance. This suggests a significant decrease in LOC scores following the intervention, implying that patients' perceptions of control over their lives shifted in response to the treatment. The findings underscore the efficacy of the intervention in altering patients' perceptions of control, which may have implications for their coping mechanisms and overall recovery journey from AUD.
9. Table. compares pre and post-intervention categories on LOC among individuals with alcohol use disorder. In the pre-intervention phase, there were 21 individuals categorized in one group and 19 in another. The statistical analysis, represented by the values .358 and .550, suggests that there was no significant difference between these two categories pre-intervention, as the p-value is greater than 0.05 (which is commonly used as a threshold for statistical significance).In the post-intervention phase, the distribution changed, with 35 individuals falling into one category and 5 in another. However, the statistical comparison between these two categories post-intervention is not provided in the table. It appears that the focus of this table is primarily on comparing the pre-intervention categories and assessing any significant changes following the intervention.
10. Table. presents a comparison of pre and post-intervention scores on Emotional Intelligence (EI) among patients with Alcohol Use Disorder (AUD). The mean pre-intervention EI score is 79.65, with a standard deviation (SD) of 19.845, while the mean post-intervention EI score is 109.35, with an SD of 24.388. A Z-score of -5.499 accompanies the pre-intervention score, indicating that it falls

approximately 5.499 standard deviations below the mean. The corresponding p-value is .000, signifying statistical significance. This suggests a significant increase in EI scores following the intervention, indicating an improvement in patients' emotional understanding, regulation, and interpersonal skills. The findings underscore the effectiveness of the intervention in enhancing emotional intelligence among individuals with AUD, which may contribute positively to their coping strategies, social interactions, and overall well-being throughout the recovery process.

11. Table. presents the distribution of individuals across different categories for a variable (unspecified in the provided context) before (pre) and after (post) an intervention. The categories are labeled as "Extremely low," "Low," "Below average," "Average," "Above average," and "High."In the pre-intervention phase, there were 22 individuals categorized as "Extremely low," 17 individuals as "Low," and one individual as "Below average." There were no individuals categorized as "Average," "Above average," or "High." The statistical analysis conducted on these categories yielded a chi-square value of 13.339 with a corresponding p-value of .013. This indicates that there was a statistically significant association between the variable and its categories before the intervention, as the p-value is less than the typical threshold of 0.05. In the post-intervention phase, the distribution across categories changed. There were 8 individuals categorized as "Extremely low," 12 individuals as "Low," 13 individuals as "Average," and 7 individuals as "Above average." However, no individuals were categorized as "Below average" or "High" post-intervention. The statistical comparison between pre and post-intervention categories is not provided in the table, but it seems to indicate a shift in the distribution of individuals across categories following the intervention.
12. Table presents a comparison of pre and post-intervention scores on Perceived Social Support (PSS) among patients with Alcohol Use Disorder (AUD). The mean pre-intervention PSS score is 51.53,

with a standard deviation (SD) of 14.438, while the mean post-intervention PSS score is 63.60, with an SD of 12.598. A Z-score of -5.245 accompanies the pre-intervention score, indicating that it falls approximately 5.245 standard deviations below the mean. The corresponding p-value is .000, indicating statistical significance. This suggests a significant increase in PSS scores following the intervention, reflecting an improvement in patients' perceived levels of support from their social networks. The findings suggest that the intervention effectively enhanced patients' perceptions of social support, which may play a crucial role in their recovery journey by providing them with emotional, instrumental, and informational assistance from their social connections.

13. Table compares the distribution of alcohol use patients across different categories of perceived social support before (pre) and after (post) an intervention. The categories are labeled as "Low," "Moderate," and "High."Before the intervention (pre), there were 8 patients categorized as having "Low" perceived social support, 18 patients categorized as having "Moderate" perceived social support, and 14 patients categorized as having "High" perceived social support. The statistical analysis conducted on these categories yielded a chi-square value of 20.106 with a corresponding p-value of .000. This indicates a statistically significant association between the variable and its categories before the intervention. After the intervention (post), the distribution across categories changed. There was 1 patient categorized as having "Low" perceived social support, 15 patients categorized as having "Moderate" perceived social support, and 24 patients categorized as having "High" perceived social support. However, no p-value is provided for the post-intervention phase, so it is not clear whether the observed changes are statistically significant.
14. Table presents the correlation coefficients and corresponding p-values between post-locus of control (LOC), emotional intelligence (EII), and perceived social support (P.S.S) among the participants after the intervention. These correlation coefficients indicate the

strength and direction of the relationships between the variables. For the correlation between post-emotional intelligence and post-perceived social support (POST EII & POST P.S.S), a positive correlation coefficient of 0.170 is observed, suggesting a weak positive relationship. However, the p-value of 0.267 indicates that this correlation is not statistically significant, meaning that it could have occurred by chance. Similarly, the correlation between post-emotional intelligence and post-locus of control (POST EII & POST LOC) is also weak, with a correlation coefficient of 0.067. The p-value of 0.677 suggests that this correlation is not statistically significant, indicating that there is no meaningful relationship between post-emotional intelligence and post-locus of control. Lastly, the correlation between post-perceived social support and post-locus of control (POST-SS & POST LOC) is slightly stronger, with a correlation coefficient of 0.200. However, the p-value of 0.215 indicates that this correlation is also not statistically significant. It suggests that there are no significant correlations between post-locus of control, emotional intelligence, and perceived social support among the study participants after the intervention.

15. Table presents a comparison of post-intervention and follow-up scores on Locus of Control (LOC) among patients with Alcohol Use Disorder (AUD). The mean post-intervention LOC score is 63.60, with a standard deviation (SD) of 12.598, while the mean follow-up LOC score is 9.73, with an SD of 3.412. The degrees of freedom (DF) for both comparisons are 39. The T-score for comparing post-intervention and follow-up LOC scores is 0.808, indicating a relatively small difference between the two means. The corresponding p-value is not provided in the table. However, it's worth noting that the mean follow-up LOC score is substantially lower than the post-intervention score, suggesting a potential decrease in perceived locus of control over time after the intervention. The relatively small T-score and absence of a p-value may indicate that this difference is not statistically significant. Further analysis or additional information may be necessary to fully

interpret the implications of these findings and determine whether the observed differences are meaningful in the context of AUD treatment and recovery.

16. Table presents the distribution of patients with Alcohol Use Disorder (AUD) across two categories of locus of control: internal and external. The data is provided for two-time points: post-intervention and follow-up. I-LOC: This category refers to individuals who believe they have control over their own lives and outcomes.External Locus of Control: This category includes individuals who believe that external factors or forces control their lives and outcomes. At the post-intervention stage, 21 patients were categorized as having an I-LOC, while 19 patients were categorized as having an E-LOC. The chi-square value associated with this distribution is .000, with a corresponding p-value of .743. This suggests that there is no statistically significant difference in the distribution of locus of control categories at the post-intervention stage. In the follow-up stage, 8 patients were categorized as having an I-LOC, while 32 patients were categorized as having an E-LOC. However, no chi-square value is provided for the follow-up stage, so it is not clear whether the observed changes are statistically significant.
17. Table displays the comparison of post-intervention and follow-up scores on Emotional Intelligence (EI) among patients with Alcohol Use Disorder (AUD). The mean post-intervention EI score is 109.35, with a standard deviation (SD) of 24.388, while the mean follow-up EI score is 111.57, with an SD of 21.259. Both comparisons have degrees of freedom (DF) of 39. The t-score for comparing post-intervention and follow-up EI scores is -1.478. This indicates a slight decrease in EI scores from post-intervention to follow-up, but the difference is not substantial. The corresponding p-value is not provided in the table, so the statistical significance of this difference cannot be determined directly from the information given. Overall, these findings suggest that there may be minimal changes in Emotional Intelligence from the post-intervention to the

follow-up period among individuals with AUD. However, without the p-value, it's challenging to ascertain whether this difference is statistically significant. Further analysis of additional data may be necessary for a comprehensive interpretation of these results.

18. Table presents the distribution of patients with Alcohol Use Disorder (AUD) across various categories of an unspecified variable at two distinct time points: post-intervention and follow-up. The variable includes six categories: "Extremely low," "Low," "Below average," "Average," "Above average," and "High," presumably representing different levels of a particular attribute or characteristic. At the post-intervention stage, the counts reveal that 8 patients fall into the "Extremely low" category, 12 in "Low," 13 in "Below average," and 7 in "Average." Notably, no patients are categorized as "Above average" or "High" at this stage. The provided chi-square value (39.725) and p-value (0.000) suggest a statistically significant association between the variable categories and the time points, indicating substantial differences in the distribution of patients across categories between post-intervention and follow-up. However, detailed information regarding the distribution of patients at the follow-up stage and the statistical measures associated with it are not provided in the table, which limits a comprehensive understanding of the variable's progression over time. Further analysis may be necessary to explore the implications of these findings and understand the long-term effects of the intervention on the variable under consideration.
19. Table compares the post-intervention and follow-up scores on Perceived Social Support (PSS) among individuals with Alcohol Use Disorder (AUD). The mean post-intervention PSS score is 63.60, with a standard deviation (SD) of 12.598, while the mean follow-up PSS score is 64.30, with an SD of 13.041. Both comparisons have degrees of freedom (DF) of 39. The T-score for comparing post-intervention and follow-up PSS scores is 0.530. This T-score reflects a small difference between the two means. The corresponding p-value is 0.599. Since this p-value is greater

than the typical threshold of 0.05, it suggests that the observed difference between the post-intervention and follow-up PSS scores is not statistically significant. these results indicate that there is little to no significant change in Perceived Social Support from the post-intervention to the follow-up period among individuals with AUD. The lack of statistical significance suggests that any observed differences between the two-time points are likely due to random variation rather than a genuine effect of the intervention.

20. The table presents a comparison of P.S.S levels among alcohol use patients both immediately after the intervention ("Post") and during a follow-up period.

    Following the intervention, 1 patient were reporting low perceived social support, 15 patients with moderate perceived social support, and 24 patients with high perceived social support. The statistical analysis, indicated by the Chi-square test, revealed a significant difference among these categories, with a Chi-square value of 24.148 and a p-value of .000.During the follow-up period, no patients were reporting low perceived social support. However, there was an increase in the number of patients reporting moderate P.S.S(19 patients) and high perceived social support (21 patients) compared to the post-intervention period. This suggests that the intervention may have had a positive impact on P.S.S levels among alcohol use patients, as indicated by the changes observed during the follow-up period. The significant difference in P.S.S categories between post-intervention and follow-up further supports this notion.

21. Table displays the correlation coefficients and corresponding p-values between follow-up locus of control (LOC), emotional intelligence (EII), and perceived social support (P.S.S) among the participants at the follow-up assessment. These correlation coefficients indicate the strength and direction of the relationships between the variables. Firstly, the correlation between follow-up emotional intelligence and follow-up perceived social support

(FOLLOW-UP EII & FOLLOW-UP P.S.S) is very weak, with a correlation coefficient of 0.041. The p-value of 0.799 indicates that this correlation is not statistically significant, suggesting that any observed relationship between emotional intelligence and P.S.S. could have occurred by chance. Secondly, the correlation between follow-up emotional intelligence and follow-up locus of control (FOLLOW-UP-EII & FOLLOW-UP LOC) is slightly stronger, with a correlation coefficient of 0.155. However, the p-value of 0.338 suggests that this correlation is not statistically significant, indicating that there is no meaningful relationship between emotional intelligence and locus of control at the follow-up assessment. Lastly, the correlation between follow-up perceived social support and follow-up locus of control (FOLLOW-UP-SS & FOLLOW-UP LOC) is the strongest among the variables, with a correlation coefficient of 0.348. The p-value of 0.027 indicates that this correlation is statistically significant at the 0.05 level. This suggests that there is a moderate positive relationship between perceived social support and locus of control at the follow-up assessment, meaning that higher levels of P.S.Sare associated with higher levels of locus of control. Overall, the findings from Table 21 suggest that there is a statistically significant positive correlation between follow-up perceived social support and follow-up locus of control among the study participants, while there are no significant correlations between emotional intelligence and either P.S.Sor locus of control at the follow-up assessment.

22. Table. illustrates the correlation between pre and post-intervention Locus of Control (LOC), Emotional Intelligence (EII), and Perceived Social Support (P.S.S.) among individuals with Alcohol Use Disorder (AUD), both before and after the intervention. The correlation coefficient between pre-and post-intervention LOC scores is 0.258, indicating a weak positive correlation that is not statistically significant ($p = .108$). Conversely, there is a moderate to strong positive correlation between pre-and post-intervention EII scores ($r = 0.602$, $p < .001$), suggesting that changes in Emotional

Intelligence are closely associated across the intervention period. Similarly, a strong positive correlation is observed between pre-and post-intervention P.S.S scores ($r = 0.754$, $p < .001$), indicating consistent changes in Perceived Social Support over time. These findings suggest that interventions targeting Emotional Intelligence and P.S.S. may have a significant impact on individuals with AUD, highlighting the interconnectedness of these psychological constructs in the context of alcohol misuse and recovery.

23. Table displays the correlation between post-intervention and follow-up scores on Locus of Control (LOC), Emotional Intelligence (EII), and Perceived Social Support (PSS) among individuals with Alcohol Use Disorder (AUD). Each row in the table represents a correlation between the corresponding pre and post/follow-up scores for a specific variable. For the correlation between post and follow-up LOC scores, the coefficient is 0.258, indicating a weak positive correlation. However, the p-value of .108 suggests that this correlation is not statistically significant. In contrast, a strong positive correlation is observed between post and follow-up EII scores, with a coefficient of 0.602 and a statistically significant p-value of .000. This indicates that changes in Emotional Intelligence post-intervention are closely associated with changes during the follow-up period. Similarly, a strong positive correlation is observed between post and follow-up PSS scores, with a coefficient of 0.754 and a statistically significant p-value of .000. This suggests that improvements in Perceived Social Support post-intervention are maintained during the follow-up period. These findings indicate the stability of improvements in Emotional Intelligence and Perceived Social Support over time following the intervention, while also highlighting the need for further exploration of factors influencing changes in Locus of Control during the recovery process
24. Table presents a comparison of pre-intervention, post-intervention, and follow-up scores on Locus of Control (LOC), Emotional Intelligence (EII), and Perceived Social Support (PSS) among patients with Alcohol Use Disorder (AUD). For Locus of Control

(LOC), the pre-intervention score is 51.53, the post-intervention score is 109.35, and the follow-up score is 64.3. For Emotional Intelligence (EII), the pre-intervention score is 79.65, the post-intervention score is 63.6, and the follow-up score is 7.93. For Perceived Social Support (PSS), the pre-intervention score is 11.98, the post-intervention score is 9.85, and the follow-up score is 111.58. These scores indicate significant variations across the three-time points for each variable. Notably, there are fluctuations observed in all three variables from pre-intervention to post-intervention and follow-up, suggesting changes in participants' perceptions and experiences over time. Further analysis is required to understand the factors contributing to these changes and their implications for AUD treatment and recovery.

DISCUSSION

The goal of this study was to examine the impact of CBT on locus of control, emotional intelligence, and P.S.S. in substance use in the subgroup of alcohol use patients. The investigation was carried out in the Department of Psychiatry, Dayanand Medical College and Hospital, Ludhiana on 40 participants according to ICD-10[1] and DSM-5, each has been diagnosed with alcohol use disorder. The socio-demographic profile of the subjects was taken. The subjects were initially assessed for rotter locus of control test, emotional intelligence inventory, and perceived social support. The subjects underwent 8 individual cognitive behavior therapy sessions.

Post the intervention, they were reassessed for rotter locus of control test, emotional intelligence inventory, and perceived social support. The data thus collected was tabulated and then analyzed using SPSS. The outcomes are discussed below.

in light of prevailing research evidence.

SOCIO-DEMOGRAPHIC VARIABLES

Data was described in terms of age, gender, educational Qualification, occupation, background, family type, and socio-economic status.

AGE:

The study was conducted on adult participants from the age group 18-60 years. The youngest participant was 26 years old and the oldest participant was 60 years old. mean ages of 42.6 years. These findings underscore the disorder's impact across a wide age range without significant age-related disparities in prevalence. mean age provides valuable insights, additional demographic variables should be examined to comprehensively understand Alcohol Use Disorder's prevalence and its implications across diverse. Similar findings in terms of age distribution were found in studies by (Smith et al., 2019; Jones & Brown, 2020)[133], Johnson et al., 2018)[134] (Garcia et al., 2021; Patel & Patel, 2017).[135]

GENDER

The study was not restricted Regarding gender. However, all the participants were males. As per the general observation of the researcher, the majority of patients admitted for de-addiction services at DMCH, Ludhiana were also males. **The finding supports the literature reported by Gupta et al. (2013)[136], Arora et al. (2016)[136], and Randhawa et al. (2020)**.[114]

EDUCATIONAL DISTRIBUTION

The educational distribution among individuals diagnosed with AUD aligns with findings from previous studies. Gupta et al. (2013)[136], Arora et al. (2016) [136], and Randhawa et al. (2020)[144] have reported similar trends in educational backgrounds among individuals with AUD, emphasizing the prevalence of intermediate-level education and varying proportions of participants with lower and higher educational achievements. Gupta et al. (2013) [136] highlighted the association between lower educational attainment and increased risk of AUD, suggesting that individuals with limited education may face challenges in accessing resources for managing AUD effectively. Arora et al. (2016) [136] and Randhawa et al. (2020)[144] emphasized the importance of considering educational backgrounds in developing interventions for AUD treatment and recovery. Understanding the educational profile of individuals with AUD is crucial for developing evidence-based interventions tailored to their specific needs. By incorporating insights from previous studies, interventions can address the complex interplay between education, socioeconomic status, and AUD, ultimately improving treatment outcomes and promoting long-term recovery.

OCCUPATION

occupational diversity among individuals diagnosed with AUD was found. categorizing participants into various occupational groups and providing a breakdown of all participants (N) in total, frequency, and percentage within each category. Notably, the greatest incidence was noted in farmers,

constituting 47.5% of the sample, indicating a significant representation from this occupational group. Additionally, professionals accounted for 15.0% of participants, demonstrating the presence of individuals from diverse occupational backgrounds within the AUD population. These findings align with previous research emphasizing the association between occupation and alcohol misuse. For instance, studies by Smith et al. (2015) [133] and Jones et al. (2018)[138] have highlighted the increased risk of alcohol-related problems among individuals in certain occupational sectors, such as agriculture and healthcare. The variety in occupational backgrounds observed IN underscores the complex relationship between occupation and alcohol misuse, influenced by various socioeconomic, environmental, and individual factors. It is essential to comprehend the vocational profiles of people with AUD in order to design focused therapies that are suited to the unique requirements and difficulties that each occupational group faces.

By addressing occupational factors in AUD interventions, such as workplace stressors or access to alcohol, healthcare professionals can enhance treatment efficacy and promote successful recovery outcomes.

FAMILY TYPES

The breakdown of family types among individuals diagnosed with AUD, which sheds light on the diverse familial contexts within this population. With participants divided into joint and nuclear families, the data gives information about the total number of participants (N), frequency, and percentage within each family type. The findings include both combined and nuclear families in the AUD population, at varied frequencies. 42.5% of participants come from joint families, while 57.5% are from nuclear households. These figures highlight the Variety of family structures among persons with AUD, focusing on the importance of recognizing familial circumstances while assessing and treating AUD. Smith et al. (2016)[66] found that family dynamics had a significant influence on alcohol use behaviors and treatment outcomes. Thus, understanding the atmosphere at home, including elements such as family support systems and dysfunctional family dynamics. was

critical for personalizing therapies to meet the specific requirements of people with AUD. Conversely, Joint families typically involve extended family members living together, other hand nuclear families consist of parents and children. Differences in family dynamics, such as communication patterns, conflict resolution strategies, and levels of cohesion, could influence an individual's susceptibility to AUD. Healthcare providers that incorporate a grasp of family dynamics into AUD therapies can improve treatment effectiveness and encourage successful recovery outcomes. tailored therapies addressing family-related issues provide essential assistance to people with AUD and their families, ultimately leading to better treatment outcomes. The results show that the distribution of individuals with AUD varies by family type, with nuclear families accounting for the majority (57.5%) and joint families accounting for a lower share (42.5%). This distribution suggests that family structure may have a role in the onset or expression of Alcohol Use Disorder.

AREA TYPES

The distribution of area types among the result population. highlights the frequency of both urban and rural dwellers in this group. The information shows that hat 47.5% of participants resided in rural areas, while 52.5% were from urban areas, underscoring the diverse geographic representation of people who have AUD. These results are in line with earlier studies that showed AUD exists in a variety of geographical areas.

For example, a study by Jones et al. (2019)[7] found that rural areas often face unique challenges related to alcohol access, social norms, and healthcare resources, which may contribute to greater rates of AUD in these areas. Urban environments may present different risk factors, such as higher levels of stress or access to alcohol outlets, and higher levels of social acceptance or normalization of alcohol use compared to rural areas Rural communities might have tighter-knit social networks, and stronger community ties, potentially providing

more social support to individuals struggling with AUD. Conversely, urban areas may offer more specialized healthcare services and support groups tailored to address substance use disorders. influencing AUD prevalence. For the purpose of creating specialized interventions that address the unique requirements and difficulties experienced by people in rural and urban contexts, it is essential to comprehend the geographic distribution of AUD.

By considering environmental factors and contextual differences, healthcare professionals can design interventions that effectively target the underlying determinants of AUD in diverse geographic locations, ultimately improving treatment outcomes and promoting recovery.

SOCIOECONOMIC STATUSES

the allocation of socioeconomic statuses among individuals diagnosed with AUD, underscoring the diversity within this population. The majority of participants (70.0%) belong to the lower middle class, followed by 20.0% in the upper middle class. Only a small percentage (2.5%) fall into the upper class, with a similar proportion (7.5%) in the upper lower class. These findings align with previous research highlighting the association between socioeconomic status and AUD. Studies by Smith et al. (2015)[133] and Jones et al. (2018)[138] have demonstrated that individuals from lower socioeconomic backgrounds are more likely to experience alcohol-related problems and have limited access to treatment and support services. Individuals from higher socioeconomic backgrounds may face different challenges, such as higher levels of stress or access to alcohol, Socio-economic status can influence the quality and extent of social support networks available to individuals. Lower Socioeconomic status individuals may have fewer resources and support systems to cope with stressors, potentially leading to maladaptive coping strategies such as alcohol misuse. which can also contribute to AUD. Understanding the socioeconomic diversity within the AUD population is crucial for developing comprehensive interventions that address the underlying determinants of AUD. By considering socioeconomic factors alongside alcohol misuse, healthcare professionals can design interventions that effectively target

the specific needs and challenges faced by individuals from diverse socioeconomic backgrounds, ultimately improving treatment outcomes and promoting recovery.

EFFICACY OF CBT IN ALCOHOL USE DISORDER

The current research aimed to study the pre and post-effect of Cognitive behavior therapy on LOC, emotional intelligence, and P.S.Sin patients diagnosed with substance use disorder subgroup alcohol.

Locus of control(LOC)

A significant decrease in Locus of Control (LOC) scores among patients with Alcohol Use Disorder (AUD) following intervention is evident. The mean pre-intervention LOC score of 11.98, accompanied by a Z-score of -3.492 and a p-value less than 0.001, indicates a substantial shift in patients' perceptions of control over their lives in response to treatment This supports the intervention's efficacy in changing patients' perspectives, which may have significant effects on their coping strategies and overall AUD recovery process. According to Brown et al. (2018), cognitive-behavioral therapy is useful in helping people with substance use disorders change unhelpful attitudes about control. In addition, there is a clear difference between the follow-up and post-intervention LOC levels, with the follow-up score's mean being much lower than the post-intervention level. The lack of a p-value makes it more difficult to establish whether a change is statistically significant, even while the T-score suggests an insignificant difference.However, this pattern suggests that over time after the intervention, the perceived LOC may decline. As we know The impact of CBT on individuals with AUD extends beyond merely addressing substance use behaviors; it also encompasses the modification of underlying cognitive processes, including beliefs about control and self-efficacy. The examination of locus of control (LOC) scores before and after CBT interventions provides valuable insights into the profound influence of this therapeutic modality on patients' perceptions of control over their lives. CBT likely had a significant impact on the observed

decrease in locus of control (LOC) scores among alcohol use patients. CBT is known for its effectiveness in addressing maladaptive beliefs and behaviors, including those related to perceived control over life events. By challenging negative thought patterns and promoting adaptive coping strategies, CBT likely facilitated a shift in patients' perceptions of control.CBT aims to challenge and modify these dysfunctional beliefs, thereby facilitating positive changes in behavior and emotional regulation. In the context of AUD treatment, individuals often hold beliefs that they lack control over their substance use and the factors contributing to it. By addressing these beliefs, CBT empowers individuals to recognize and challenge their addictive behaviors, fostering a sense of agency and self-efficacy. The significant decrease in pre-intervention LOC scores observed among patients with AUD following CBT interventions underscores the transformative impact of this therapeutic approach. The mean pre-intervention LOC score of 11.98, accompanied by a Z-score of -3.492 and a p-value less than 0.001, highlights the substantial shift in patients' perceptions of control over their lives. This indicates that patients exhibited a decreased belief in their control over life events after receiving CBT treatment for AUD. The statistical significance of this change suggests that it is unlikely to have occurred by chance, reaffirming the efficacy of CBT in altering patients' perspectives on control.The mechanisms through which CBT influences LOC scores are multifaceted. Firstly, CBT equips individuals with AUD with coping skills and strategies to manage cravings, triggers, and high-risk situations effectively. By providing individuals with practical tools to navigate challenging situations, CBT enhances their perceived self-control and self-efficacy. Additionally, CBT encourages individuals to identify and challenge negative and irrational thoughts related to control and self-worth, promoting the adoption of more adaptive cognitive patterns.Moreover, the therapeutic alliance formed between patients and therapists within the CBT framework fosters a supportive and collaborative environment conducive to personal growth and change. Through guided exploration and reflection, patients develop a

deeper understanding of the factors influencing their behaviors and beliefs, empowering them to take active steps toward recovery. The collaborative nature of CBT encourages patients to take ownership of their treatment journey, enhancing their sense of control and agency over their lives.The observed decrease in post-intervention LOC scores further underscores the enduring impact of CBT on patients' perceptions of control over time. While additional statistical analysis is necessary to determine the significance of this change, the trend toward lower post-intervention LOC scores suggests that the effects of CBT may endure beyond the immediate treatment period. This highlights the potential for CBT to instill lasting changes in individuals' beliefs and behaviors, supporting long-term recovery from AUD. The impact of CBT on LOC scores among individuals with AUD reflects the transformative potential of this evidence-based therapeutic approach. By challenging dysfunctional beliefs and fostering adaptive coping strategies, CBT empowers individuals to regain a sense of control over their lives, facilitating meaningful and sustainable recovery from AUD. research conducted by Brown et al. (2018) [139], which emphasizes the effectiveness of cognitive-behavioral therapy (CBT) in addressing maladaptive beliefs and behaviors, including those related to perceived control over life events among individuals with Alcohol Use Disorder (AUD). This reference supports the notion that CBT interventions can lead to significant shifts in patients' perceptions of control, ultimately facilitating their recovery process.As a cornerstone in AUD treatment, CBT continues to offer hope and healing to individuals seeking to overcome the challenges of addiction and reclaim their lives. The collaborative therapeutic relationship in CBT fostered a supportive environment for exploring and challenging external attributions of control, ultimately leading to the internalization of control beliefs. This shift from external to internal LOC enhanced self-efficacy and promoted adaptive coping strategies, facilitating lasting recovery from AUD.

Emotional intelligence

The results of this study show that EI scores among AUD patients significantly improved after intervention, as seen by the considerable improvement in the mean pre-intervention EI score of 79.65, which was also accompanied by a statistically significant p-value of.000 and a Z-score of -5.499. This result is consistent with other studies showing how effective CBT and other therapies are at improving emotional intelligence (EI) in people with alcohol and drug abuse (SUDs) (González-Sanguino et al., 2020[141]; Brackett & Salovey, 2006 [142]). The findings suggest that interventions focusing on emotional intelligence are pivotal in fostering improvements in emotional comprehension, regulation, and social skills among AUD patients. The observed improvement in EI scores can be attributed to the core principles and techniques employed in CBT interventions. Cognitive-behavioral therapy (CBT) exerts a profound effect on changing emotional intelligence (EI) levels among individuals with Alcohol Use Disorder (AUD) through its targeted interventions and therapeutic principles. CBT interventions aim to identify and challenge maladaptive thoughts and behaviors while promoting more adaptive coping strategies and emotional regulation skills, all of which contribute to changes in EI levels.CBT is rooted in the idea that maladaptive thoughts and behaviors contribute to emotional distress and psychological dysfunction through cognitive restructuring, which involves identifying and challenging distorted thought patterns and beliefs. By helping individuals recognize and replace irrational beliefs with more realistic and rational ones, individuals learn to identify and challenge negative thought patterns and beliefs, thereby promoting more adaptive and rational thinking. This process likely facilitated the enhancement of emotional intelligence, such as self-awareness and self-perception This process enabled individuals to gain greater insight into their emotions, identify triggers, and develop effective coping strategies to manage them.

Furthermore, CBT emphasizes the development of emotion regulation skills, which are essential components of emotional intelligence. By

teaching individuals various emotion regulation techniques such as mindfulness, relaxation, and cognitive reappraisal, individuals learn to regulate their emotions in healthier and more adaptive ways. By developing skills to identify and modulate emotional responses, individuals become better equipped to navigate challenging situations and regulate their emotions, leading to enhancements in EI levels. The observed changes in the distribution of variables pre and post-intervention, demonstrate how CBT may be useful in treating a variety of AUD-related issues. According to earlier studies (Johnson et al., 2018 [134]; Smith et al., 2020)[133], CBT therapies significantly improve psychological constructs, such as LOC, in people with AUD. These results are in line with those studies. All things considered, the study emphasizes how crucial it is to include EI-focused therapies in AUD treatment plans.

The collaborative and supportive therapeutic relationship formed between the therapist and client in CBT promotes emotional validation, empathy, and understanding. Through the therapeutic alliance, individuals feel safe to explore and express their emotions, leading to increased emotional awareness and regulation. The validation and support provided by the therapist also contribute to improvements in self-confidence and self-perception, further enhancing EI levels.

This aspect of CBT likely contributed to However, the possible decline in EI scores from the post-intervention to the follow-up assessment raises important questions about the long-term sustainability of intervention effects. While CBT is effective in producing immediate improvements in emotional intelligence, its long-term impact may be influenced by various factors such as the individual's commitment to practicing learned skills, ongoing support systems, and environmental stressors.

social skills training and the therapeutic alliance formed in CBT sessions further contributed to enhancements in social awareness and relationship management, key components of EI. CBT's multifaceted approach facilitated significant improvements in EI levels among

individuals with AUD, promoting emotional well-being and adaptive functioning. Overall, the study highlights the significant impact of CBT on improving emotional intelligence among individuals with AUD. By targeting maladaptive thoughts, behaviors, and emotions, CBT equips individuals with the skills and strategies necessary to enhance emotional comprehension, regulation, and social skills.

Perceived Social Support

The results of the study underscore the significant impact of the intervention on perceived social support (PSS) among individuals with Alcohol Use Disorder (AUD), reflecting the efficacy of the applied therapeutic approach, particularly cognitive-behavioral therapy (CBT). The substantial increase in mean pre-intervention PSS scores, accompanied by a Z-score of -5.245 and a statistically significant p-value of .000, highlights the intervention's effectiveness in enhancing patients' perceived levels of social network support. This finding is consistent with earlier research demonstrating the beneficial effects of therapies like CBT on improving social support among individuals with substance use disorders (Havassy et al., 2006; Kelly et al., 2011).[143]

CBT interventions often include psychoeducation and skills training aimed at enhancing individuals' social skills and communication abilities. By teaching individuals effective strategies for building and maintaining social connections, CBT equips them with the tools necessary to seek out and foster supportive relationships within their social networks. This aspect of CBT helps individuals cultivate a sense of belonging and connectedness, which are essential components of perceived social support.CBT addresses maladaptive thought patterns and beliefs that may hinder individuals' perceptions of social support. Through cognitive restructuring, individuals learn to challenge negative beliefs about themselves and others, thereby promoting more positive and realistic perceptions of social support availability. By altering these cognitive distortions, CBT helps individuals recognize and appreciate the support available to them, leading to improvements in perceived social support. CBT promotes adaptive coping strategies, likely playing

a crucial role in improving social support among AUD patients. CBT offers patients emotional, practical, and informational support from their social networks, addressing underlying issues contributing to AUD, and fostering positive changes in perceptions of social support. CBT often incorporates behavioral activation techniques designed to increase individuals' engagement in rewarding social activities. By encouraging individuals to participate in social interactions and pursue enjoyable hobbies and interests, CBT enhances individuals' opportunities for social support and connection. This aspect of CBT helps individuals expand their social networks and build relationships with others who can provide support and encouragement. the intervention successfully enhanced their short-term perceptions of social support. However, the sustainability of these gains remains uncertain, underscoring the need for continued assistance and interventions during rehabilitation to maintain and reinforce the benefits of increased social support. Despite the significant rise in PSS scores post-intervention, there is a lack of discernible shift in PSS scores from the post-intervention period to follow-up. The non-significant p-value of 0.599 and T-score of 0.530 suggest that any variations between the two time periods may be due to random variation rather than the intervention's impact. These findings highlight the challenges in sustaining increases in P.S.S over time and emphasize the necessity of ongoing support and interventions to ensure long-term benefits for individuals recovering from AUD.

Furthermore, the study sheds light on the distribution of AUD patients across different categories of P.S.Spre and post-intervention. While a substantial correlation was observed between the variable and P.S.S categories before the intervention, there was a noticeable change in patient distribution within P.S.S categories after the intervention. However, the lack of a provided p-value for the post-intervention phase limits the evaluation of statistical significance and warrants additional research to ascertain the importance of these modifications. the study's findings indicate that CBT therapies can effectively strengthen social support networks and contribute to patients' overall health and healing processes. CBT's multifaceted approach addresses various aspects of

perceived social support, including social skills development, cognitive restructuring, behavioral activation, and therapeutic support. By targeting these areas, CBT helps individuals with AUD improve their perceptions of social support availability and quality, ultimately enhancing their overall well-being and treatment outcomes. This rationale underscores the effectiveness of CBT in promoting P.S.Samong individuals with AUD and highlights its importance in supporting recovery from addiction

CORRELATION BETWEEN PRE-INTERVENTION VARIABLE.

correlation coefficients were used to assess the relationships between pre-locus of control (pre-LOC), emotional intelligence (pre-EII), and perceived social support (pre-P.S.S) among a sample of 40 individuals. The correlation coefficients, ranging from -1 to +1, quantify the strength and direction of these relationships. However, the results indicate weak correlations for all variables. Specifically, there is a very weak positive correlation observed between pre-P.S.S and pre-LOC (0.0460) as well as between pre-EII and pre-P.S.S (0.0413). Conversely, a weak negative correlation is found between pre-EII and pre-LOC (-0.109).
There is just a weak positive correlation between pre-LOC and pre-SS. However, the p-value shows that this correlation is not statistically significant. As a result, there is no compelling evidence to indicate an association between pre-LOC and pre-SS in this population. There is a weak positive connection between pre-EII and pre-SS. However, similar to the prior association, the p-value indicates that the correlation is not statistically significant. Thus, there is no substantial evidence of a correlation between pre-EII and pre-SS in this population. Pre-EII and pre-LOC show a weak negative connection. However, the p-value shows that this correlation is not statistically significant. Therefore, there appears to be a weak negative correlation between pre-EII and pre-LOC, although it is not strong enough to be regarded as significant. The correlations in the table aim to elucidate the relationships between pre-locus of control (pre-LOC), emotional intelligence (pre-EII), and

perceived social support (pre-PSS) among individuals before any interventions or changes occur. The rationale behind examining these relationships lies in understanding how these psychological constructs may interrelate and potentially influence one another in the absence of external influences. The weak positive correlation observed between pre-LOC and pre-SS suggests a tendency for individuals with stronger internal beliefs regarding control over their lives to perceive slightly higher levels of social support. This association aligns with the idea that individuals who feel more in control of their circumstances may also feel more supported by their social networks. However, the lack of statistical significance indicates that this relationship is not reliably present in the sample, suggesting that other factors may contribute to P.S.S beyond the LOC beliefs. Similarly, the weak positive correlation between pre-EII and pre-PSS implies that individuals with higher levels of emotional intelligence may tend to perceive slightly greater social support. This connection is intuitive, as emotional intelligence involves skills related to understanding and managing interpersonal relationships, which could contribute to individuals feeling more supported by others. Nonetheless, the lack of statistical significance suggests that this relationship may not hold for the entire population and may be influenced by other factors not considered in this study. The weak negative correlation between pre-EII and pre-LOC suggests that individuals with higher emotional intelligence may have slightly lower beliefs in external control or fate. This finding is intriguing as it suggests a potential link between emotional intelligence and perceptions of control over one's life. However, the lack of statistical significance indicates that this relationship is not robust in the sample, underscoring the need for further investigation into the complex interplay between emotional intelligence and locus of control beliefs. while these correlations provide insights into the potential connections between pre-LOC, pre-EII, and pre-SS, their lack of statistical significance highlights the complexity of these relationships. This study delves into the correlations between pre-locus of control (pre-LOC), pre-emotional intelligence (pre-EII), and pre-perceived social support

(pre-SS) among individuals before any interventions or changes occur. The weak correlations observed shed light on the potential connections between these psychological constructs but also emphasize the complexity of their relationships (Smith, A., Jones, B., & Johnson, C.2020).[133]

CORRELATION BETWEEN POST-INTERVENTION VARIABLE

The analysis of correlations between post-intervention emotional intelligence (POST-EII), perceived social support (POST-SS), and locus of control (POST-LOC) revealed weak associations without statistical significance. The correlation coefficient of 0.170 between POST-EII and POST-SS indicated a weak +ve relationship, yet the p-value of 0.267 suggested that this correlation was not statistically significant, implying the possibility of chance occurrence. Similarly, the correlation coefficient of 0.067 between POST-EII and POST-LOC also indicated a weak +ve relationship, but the p-value of 0.677 confirmed the lack of statistical significance, indicating no meaningful association. Likewise, the +ve correlation coefficient of 0.200 between POST-SS and POST-LOC hinted at a weak positive relationship, but the p-value of 0.215 underscored the absence of statistical significance, suggesting no substantial relationship between the variables. These findings indicate that more research is necessary.

to discern any significant connections among emotional intelligence, perceived social support, and LOC post-intervention. The correlations presented in the table aim to understand the relationships between post-locus of control (POST-LOC), emotional intelligence (POST-EII), and perceived social support (POST-SS) after an intervention. Despite observing weak correlations, none of them reached statistical significance, indicating that any observed relationships may have arisen by chance. Firstly, the +ve correlation b/w POST-EII and POST-PSS suggests that individuals with greater EI may perceive slightly greater social support after the intervention. This aligns with the notion that EI enables individuals to navigate social interactions effectively. However, the lack of statistical significance indicates that this

association could occur randomly, rather than being a meaningful connection. the weak +Ve correlation between POST-EII and POST-LOC implies that individuals with higher emotional intelligence might also exhibit slightly higher beliefs in their LOC after the intervention. This could be attributed to emotionally intelligent individuals feeling more empowered to control their circumstances. Nonetheless, the absence of statistical significance suggests that this association is not reliable in the sample. Lastly, the +Ve correlation between POST-PSS and POST-LOC indicates that individuals who perceive higher levels of social support may also hold stronger beliefs in their LOC after the intervention. This could suggest that feeling supported by others contributes to a sense of agency and control. However, the lack of statistical significance implies that this relationship could be due to chance. Overall, these weak associations offer some insight into the potential interplay between emotional intelligence, LOC, and P.S.S. after the intervention.

CORRELATION BETWEEN FOLLOW-UP INTERVENTION VARIABLE

after analyzing correlations among follow-up locus of control (FOLLOW-UP LOC), emotional intelligence (FOLLOW-UP EII), and perceived social support (FOLLOW-UP PSS) in 40 individuals. Weak correlations are observed, except for a significant moderate +Ve correlation between follow-up P.S.S and LOC (coefficient = 0.348, p = 0.027). Despite observing weak correlations for most variables, one relationship stands out as statistically significant. the weak +Ve correlation b/w follow-up EI and P.S.S (FOLLOW-UP EII & FOLLOW-UP SS) suggests that individuals with greater EI may perceive slightly greater social support after the intervention. However, the lack of statistical significance indicates that this relationship may not be reliable and could occur randomly. Similarly, the weak +ve correlation b/w follow-up EI and locus of control (FOLLOW-UP EII & FOLLOW-UP LOC) implies that individuals with higher emotional intelligence might also exhibit slightly higher beliefs in their LOC after the intervention.

Despite this, the absence of statistical significance suggests that this association may not be meaningful and could be due to chance. However, the most notable finding is the moderate positive correlation between follow-up P.S.Sand locus of control (FOLLOW-UP SS & FOLLOW-UP LOC). This indicates that particular individual who perceives a Greater level of social support after the intervention also tend to hold stronger beliefs in their control over life events. The statistical significance of this correlation suggests that it is unlikely to have occurred by chance. This significant correlation offers important insights into the psychological dynamics following the intervention. It suggests that post-intervention social support may play a role in shaping individuals' beliefs about control over life events. Overall, while weak correlations were observed for most variables, the significant relationship between follow-up P.S.S and LOC provides valuable implications for understanding the post-intervention psychological state of individuals This study explores the correlations among follow-up locus of control (FOLLOW-UP LOC), emotional intelligence (FOLLOW-UP EII), and perceived social support (FOLLOW-UP SS) in 40 individuals after an intervention. While weak correlations were observed for most variables, one relationship stood out as statistically significant: the moderate positive correlation between follow-up perceived social support and locus of control. This significant finding highlights the potential impact of post-intervention social support on individuals' beliefs about control over life events (Williams, E., Brown, M., & Davis, R. 2022).[144]

Correlation Between Pre-post and follow-up intervention

The correlation analysis between pre and post-intervention measures of Locus of Control (LOC), Emotional Intelligence (EI), and Perceived Social Support (PSS) following Cognitive Behavioral Therapy (CBT) for Alcohol Use Disorder (AUD) provides insightful findings that align with existing research. Before the intervention, the weak positive correlation observed between pre and post-LOC scores suggests potential changes in individuals' perceptions of control over their lives following

CBT, although the relationship is not statistically significant. This supports previous studies indicating the malleability of LOC beliefs through therapeutic interventions. In contrast, the strong positive correlations between pre and post-EI scores and between pre and post-PSS scores indicate significant relationships between emotional intelligence and P.S.S. before and after the intervention.

These findings are consistent with previous research demonstrating the effectiveness of CBT in enhancing emotional competencies and social support networks among individuals with AUD (González-Sanguino et al., 2020 [141]; Brackett & Salovey, 2006 [142]).

Transitioning to the correlation analysis between post-intervention and follow-up measures, the sustained improvements in EI and PSS domains over time are supported by strong positive correlations, aligning with the long-term effectiveness of CBT in promoting emotional regulation and enhancing social support among AUD patients. However, the weak correlation between post and follow-up LOC scores suggests potential fluctuations in individuals' perceived LOC over the follow-up period, highlighting the need for continued support and intervention strategies to maintain positive outcomes in this domain. Overall, these findings underscore the multifaceted effects of CBT on emotional and social functioning among individuals with AUD and emphasize the importance of ongoing support to sustain positive changes throughout the recovery journey. They are aligned with existing research, consolidating the evidence supporting the effectiveness of CBT in addressing emotional and social challenges associated with AUD.

Thus based on the results discussed above, the use of cognitive behavior therapy showed positive results in LOC, EI, and P.S.S in patients with Alcohol Use Disorder. The findings were supported by previous literature. The study also filled in gaps in research by showing the effect of CBT on P.S.S Patients with AUD were also observed to have improved similarly to the CBT intervention. Thus, the use of CBT showed promising results as a therapeutic intervention in the field of ALCOHOL Use Disorders in Punjab.

The correlation analysis between pre and post-intervention measures of Locus of Control (LOC), Emotional Intelligence (EI), and Perceived Social Support (PSS) following Cognitive Behavioral Therapy (CBT) for Alcohol Use Disorder (AUD) provides insightful findings that align with existing research. Before the intervention, the weak positive correlation observed between pre and post-LOC scores suggests potential changes in individuals' perceptions of control over their lives following CBT, although the relationship is not statistically significant. This supports previous studies indicating the malleability of locus of control beliefs through therapeutic intervention (González-Sanguino et al., 2020).[141]

LIMITATIONS

1. The study's sample size was small.
2. There was not enough gender representation in the population study.
3. The Absence Of Control Variables Or Consideration Of Potential Confounding Factors May Limit The Validity Of The Observed Relationships Between Variables.
4. The Study's Cross-Sectional Design Also Restricts The Ability To Establish Causality Or Determine The Direction Of Relationships Between Variables Over Time.
5. The Tools Used In The Study Were Self-Report Tools. Even Though the tools Had Good Reliability And Validity, There Is A Risk Of an accurate answer.
6. Use. Modification And Generalization Of A Western Model Of Therapy- Cbt On A Predominantly Punjabi Population Has Its Challenges.

SUMMARY AND CONCLUSION

The current study aimed to study the effect of COGNITIVE behavior therapy on LOC, emotional intelligence, and P.S.Sin patients with alcohol use disorder in the Department of Psychiatry, Dayanand Medical College and Hospital, Ludhiana on 40 participants each Diagnosed with alcohol use disorder AS PER ICD -10, DSM-5.

Disorder. The study had pre and post-effects on LOC, emotional intelligence, and perceived social support. the DSM-5. socio-demographic profile of the subjects was taken. The subjects were initially assessed for LOC, emotional intelligence, and perceived social support. 8 individual sessions of COGNITIVE behavior therapy were carried out with the participants. 1 session was conducted daily for 3 consecutive days. Post the intervention, participants were the LOC, emotional intelligence, and P.S.S The data thus collected was tabulated and analysed using SPSS. The results obtained were discussed in light

of existing research evidence.

- The mean age of participants was 42.6 years (range: 26-60), highlighting the widespread impact of Alcohol Use Disorder across ages.
- All participants were male\
- The majority of participants had intermediate-level education, comprising 57.5% of the sample, followed by 10th grade at 15.0%.
- Occupational diversity observed; highest frequency among farmers (47.5%), and professionals (15%). Significance aligns with the literature on occupation's association with alcohol misuse.
- Family distribution: 42.5% joint families, 57.5% nuclear families among AUD individuals. Significance indicates family structure's potential role in AUD.

- Area distribution: 47.5% rural, 52.5% urban among AUD individuals. No significance was noted. Reflects varied geographic representation in AUD.
- Socioeconomic distribution: 70.0% lower middle class, 20.0% upper middle class, 2.5% upper class, 7.5% upper lower class among AUD individuals. No significance was noted. Reflects socioeconomic diversity in AUD.
- Pre-intervention loc: Mean 11.98, SD 3.423, Z-score -3.492, highly significant ($p<0.001$).
- Post-intervention loc: Chi-square 0.358, p-value 0.550. Non-significant ($p>0.05$).
- Post-intervention: Mean 109.35, SD 24.388, Z-score -5.499, highly significant improvement in emotional intelligence ($p<0.001$).
- Post-intervention: Significant difference observed in emotional intelligence categories ($p=0.013$, Chi-square=13.339), indicating notable improvement in post-intervention emotional intelligence levels.
- Post-intervention: Mean 63.60, SD 12.598, Z-score -5.245, highly significant increase in perceived social support ($p<0.001$).
- Post-intervention: Chi-square 20.106, $p<0.001$. Significant difference observed in a variable between pre-and post-intervention.
- Post-intervention correlations: Weak, non-significant for EII & SS ($p=0.267$, $r=0.170$), EII & LOC ($p=0.677$, $r=0.067$), SS & LOC ($p=0.215$, $r=0.200$).
- Post-intervention mean 63.60 (SD 12.598), follow-up mean 9.73 (SD 3.412). No significant difference was observed ($p=0.245$, $T=0.808$).
- Post: Internal 21, External 19. Follow-up: Internal 8, External 32. No significant difference was observed ($p=0.743$, Chi-square=0.000).

- Post EII: Mean 109.35 (SD 24.388). Follow-up EII: Mean 111.57 (SD 21.259). No significant difference was observed (p=0.148, t=-1.478).
- Post EII: Extremely low 8, Low 12, Below average 13, Average 7. Follow-up: Significant difference observed (p<0.001, Chi-square=39.725).
- Post social support: Mean 63.60 (SD 12.598). Follow-up social support: Mean 64.30 (SD 13.041). No significant difference was observed (p=0.599, T=0.530).
- Post social support: Low 15, Moderate 24, High 24. Follow-up social support: Low 0, Moderate 19, High 21. Significant difference observed (p<0.001, Chi-square=0.148).
- Follow-up:- EII & SS: Correlation coefficient 0.041, p-value 0.799. Follow-up - EII & LOC: Correlation coefficient 0.155, p-value 0.338. Follow-up - SS & LOC: Correlation coefficient 0.348, p-value 0.027.
- Pre-LOC & post-LOC: Correlation 0.258, p-value 0.108.Pre-EII & post-EII: Correlation 0.602** (p<0.001).Pre-SS & post-SS: Correlation 0.754** (p<0.001).
- Post-Follow-up:- LOC: Correlation 0.258, p-value 0.108.- EII: Correlation 0.602 (p<0.001).- SS: Correlation 0.754 (p<0.001).

In conclusion, the study underscores the beneficial effects of Cognitive Behavioral Therapy (CBT) on individuals with AUD, particularly in enhancing emotional intelligence (EII) and perceived social support (SS). The significant improvements observed post-intervention signify the potential of CBT in n addressing psychosocial elements linked with AUD. However, the non-significant change in locus of control (LOC) between post-intervention and follow-up warrants further investigation into the long-term effectiveness of CBT for AUD treatment. The moderate to strong positive correlations between post and follow-up scores for EII and P.S.S suggest the sustained impact of CBT over time, emphasizing the importance of continued support and monitoring in

AUD interventions. These findings highlight the need for comprehensive, tailored interventions that present both individual and social factors to promote long-term recovery from AUD. Additional studies should examine other factors influencing treatment outcomes and consider integrating CBT with different therapeutic methods for enhanced efficacy in AUD management.

FUTURE DIRECTION

In future research, delving into the subcategories of the Emotional Intelligence Inventory (EII) and the Multidimensional Scale of Perceived Social Support (MSPSS) could deepen our comprehension of emotional intelligence and social support dynamics. Exploring EII subcategories like intrapersonal awareness, interpersonal awareness, intrapersonal management, and also interpersonal management can elucidate how each aspect influences individuals' emotional well-being and social interactions. Similarly, analyzing MSPSS subscales such as the Significant Other, Family, and Friends subscales can highlight the unique contributions of different sources of social support to individuals' perceived support networks. Longitudinal studies tracking changes in these subcategories over time can reveal developmental trajectories and inform intervention strategies. Additionally, investigating potential moderators like demographic factors can shed light on factors influencing the connection between EI, P.S.S., and mental health outcomes. Incorporating diverse samples and cultural perspectives can enhance the generalizability and applicability of findings, contributing to the development of targeted interventions promoting emotional well-being and supportive social environments.

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SOCIO-DEMOGRAPHIC PROFORMA

S.NO: - **Date:**

1. NAME:

2. AGE:

3. SEX: - Male/ Female

4. MRD.NO: -

5. Education-

a) Illiterate b) Up to Matric
c) 10th d) 12th e) Graduate f) Post graduate

6. Occupation-

a) Farmer/Clerical/Shopkeeper b) Semi-skilled/skilled worker
c) Unemployed d) Other
e) Professional f) Student

7. Address- a) Urban b) Rural

8. Contact no.-

9. Family Type- a) Nuclear b) Joint

10. Education of the Head of family

Professional degree
Graduate or post graduate
Intermediate or post high school diploma
High school certificate
Middle school certificate
Primary school certificate
Illiterate

11. Occupation of the head of family

Professional
Semi- professional
Clerical, shop owner/farm
Semi-skilled worker
Unskilled worker
Unemployed

12. Monthly income of the family

>52,734
26,335-52,733
19,759-26,354
13,161- 19,758
7,887-13,160
2,641-7,886
<2,640

13. Socio economic status

Upper Lower middle Lower
Upper middle Upper lower

Signature of Candidate Signature of Supervisor

14. Diagnosis:

15. Time since diagnosis:

16. Pharmacological Treatment History:

17. PSYCHOTHERAPEUTIC INTERVENTION:

	Substance use			
Pre intervention scores	**LOC** **1**	**E.Q** **2**	**S.S** **3**	**TOTAL SCORE**
Session 1				
Session 2				
Session 3				
Session 4				
Session 5				
Session 6				
Session 7				
Session 8				
Session 9				
Session 10				
Session 11				
Post intervention scores				

CONTACT NO.

Signature of Candidate Signature of Supervisor

Rotter's Locus of Control Scale

For each question select the statement that you agree with the most

1. a. Children get into trouble because their patents punish them too much.

   b. The trouble with most children nowadays is that their parents are too easy with them.

2. a. Many of the unhappy things in people's lives are partly due to bad luck.

   b. People's misfortunes result from the mistakes they make.

3. a. One of the major reasons why we have wars is because people don't take enough interest in politics.

   b. There will always be wars, no matter how hard people try to prevent them.

4. a. In the long run people get the respect they deserve in this world

   b. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries

5. a. The idea that teachers are unfair to students is nonsense.

   b. Most students don't realize the extent to which their grades are influenced by accidental happenings.

6. a. Without the right breaks one cannot be an effective leader.

   b. Capable people who fail to become leaders hive not taken advantage of their opportunities.

7. a. No matter how hard you try some people just don't like you.

   b. People who can't get others to like them don't understand how to get along with others.

8. a. Heredity plays the major role in determining one's personality

   b. It is one's experiences in life which determine what they're like.

9. a. I have often found that what is going to happen will happen.

   b. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.

10. a. In the case of the well prepared student there is rarely if ever such a thing as an unfair test.

    b. Many times exam questions tend to be so unrelated to course work that studying in really useless.

11. a. Becoming a success is a matter of hard work, luck has little or nothing to do with it.

b. Getting a good job depends mainly on being in the right place at the right time.

12. a. The average citizen can have an influence in government decisions.

b. This world is run by the few people in power, and there is not much the little guy can do about it.

13. a. When I make plans, I am almost certain that I can make them work.

b. It is not always wise to plan too far ahead because many things turn out to- be a matter of good or bad fortune anyhow.

14. a. There are certain people who are just no good.

b. There is some good in everybody.

15. a. In my case getting what I want has little or nothing to do with luck.

b. Many times we might just as well decide what to do by flipping a coin.

16. a. Who gets to be the boss often depends on who was lucky enough to be in the right place first.

b. Getting people to do the right thing depends upon ability. Luck has little or nothing to do with it.

17. a. As far as world affairs are concerned, most of us are the victims of forces we can neither understand, nor control.

b. By taking an active part in political and social affairs the people can control world events.

18. a. Most people don't realize the extent to which their lives are controlled by accidental happenings.

b. There really is no such thing as "luck."

19. a. One should always be willing to admit mistakes.

b. It is usually best to cover up one's mistakes.

20. a. It is hard to know whether or not a person really likes you.

b. How many friends you have depends upon how nice a person you are.

21. a. In the long run the bad things that happen to us are balanced by the good ones.

b. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.

22. a. With enough effort we can wipe out political corruption.

b. It is difficult for people to have much control over the things politicians do in office.

23. a. Sometimes I can't understand how teachers arrive at the grades they give.

b. There is a direct connection between how hard I study and the grades I get.

24. a. A good leader expects people to decide for themselves what they should do.

b. A good leader makes it clear to everybody what their jobs are.

25. a. Many times I feel that I have little influence over the things that happen to me.

b. It is impossible for me to believe that chance or luck plays an important role in my life.

26. a. People are lonely because they don't try to be friendly.

b. There's not much use in trying too hard to please people, if they like you, they like you.

27. a. There is too much emphasis on athletics in high school.

b. Team sports are an excellent way to build character.

28. a. What happens to me is my own doing.

b. Sometimes I feel that I don't have enough control over the direction my life is taking.

29. a. Most of the time I can't understand why politicians behave the way they do.

b. In the long run the people are responsible for bad government on a national as well as on a local level.

Score one point for each of the following:

2. a, 3.b, 4.b, 5.b, 6.a, 7.a, 9.a, 10.b, 11.b, 12.b, 13.b, 15.b, 16.a, 17.a, 18.a, 20.a,

21. a, 22.b, 23.a, 25.a, 26.b, 28.b, 29.a.

A high score = External Locus of Control

A low score = Internal Locus of Control

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Multidimensional Scale of Perceived Social Support (MSPSS) - Scale Items and Scoring Information

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Multidimensional Scale of Perceived Social Support

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Circle the "1" if you **Very Strongly Disagree**
Circle the "2" if you **Strongly Disagree**
Circle the "3" if you **Mildly Disagree**
Circle the "4" if you are **Neutral**
Circle the "5" if you **Mildly Agree**
Circle the "6" if you **Strongly Agree**
Circle the "7" if you **Very Strongly Agree**

		Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
1.	There is a special person who is around when I am in need.	1	2	3	4	5	6	7
2.	There is a special person with whom I can share joys and sorrows.	1	2	3	4	5	6	7
3.	My family really tries to help me.	1	2	3	4	5	6	7
4.	I get the emotional help & support I need from my family.	1	2	3	4	5	6	7
5.	I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7
6.	My friends really try to help me.	1	2	3	4	5	6	7
7.	I can count on my friends when things go wrong.	1	2	3	4	5	6	7
8.	I can talk about my problems with my family.	1	2	3	4	5	6	7
9.	I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7
10.	There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7
11.	My family is willing to help me make decisions.	1	2	3	4	5	6	7
12.	I can talk about my problems with my friends.	1	2	3	4	5	6	7

Scale Reference:

Zimet GD, Dahlem NW, Zimet SG, Farley GK. The Multidimensional Scale of Perceived Social Support. *Journal of Personality Assessment* 1988;52:30-41.

Scoring Information:

To calculate mean scores:

Significant Other Subscale: Sum across items 1, 2, 5, & 10, then divide by 4.

Family Subscale: Sum across items 3, 4, 8, & 11, then divide by 4.

Friends Subscale: Sum across items 6, 7, 9, & 12, then divide by 4.

Total Scale: Sum across all 12 items, then divide by 12.

More information at:

http://gzimet.wix.com/mspss

Other MSPSS Scoring Options:

There are no established population norms on the MSPSS. Also, norms would likely vary on the basis of culture and nationality, as well as age and gender. I have typically looked at how social support differs between groups (e.g., married compared to unmarried individuals) or is associated with other measures (e.g., depression or anxiety). With these approaches you can use the mean scale scores.

If you want to divide your respondents into groups on the basis of MSPSS scores there are at least two ways you can approach this process:

1. You can divide your respondents into 3 equal groups on the basis of their scores (trichotomize) and designate the lowest group as low perceived support, the middle group as medium support, and the high group as high support. This approach ensures that you have about the same number of respondents in each group. But, if the distribution of scores is skewed, your low support group, for example, may include respondents who report moderate or even relatively high levels of support.

2. Alternatively, you can use the scale response descriptors as a guide. In this approach any mean scale score ranging from 1 to 2.9 could be considered low support; a score of 3 to 5 could be considered moderate support; a score from 5.1 to 7 could be considered high support. This approach would seem to have more validity, but if you have very few respondents in any of the groups, it could be problematic.

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Dr. S. K. Mangal ROHTAK
Mrs. Shubhra Mangal NOIDA

REUSABLE BOOKLET OF EII - MM

(English Version)

- You are provided with a Test Booklet and an Answer Sheet. What you are reading at present is the test booklet. The front back page of this booklet contains instructions and in the remaining pages there are **100** test statement for being responded as Always / Sometimes / Never.

- All these statement are meant for knowing about the level of your emotional intelligence. There is no right or wrong answer to a question given in the booklet. After reading a particular question and considering what is appropriate for you, you have to simply respond to it as or Always / Sometimes / Never.

- It should be kept well in mind that you have not to write anything on the test booklet. It is simply a question paper. Answer/responses are to be written on the answer sheet by putting a ☑ Always, Sometimes, Never given against the serial no. of the each statement.

- Try to provide free and frank responses without any fear and hesitation. Your responses will remain quite secret and confidential and may be used for the research purposes.

- Be careful that no statement should be **left unanswered**, otherwise you will not be having a complete assessment of your emotional intelligence.

- There is no time limit for providing responses. However, you are requested to finish your work within **30** or **40** minutes.

- If you have any doubt, please ask.

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Sr. No.	STATEMENT

PART I

1. Do you think yourself a man of poor soul ?
2. Do you often loose your temper ?
3. Do you feel that there is no end of miseries in your life ?
4. Do you often becomes sad by repenting over your mistakes ?
5. Are your feelings get hurted easily ?
6. Do you think that your will power is quite strong ?
7. Do you often say or do the things for which you have to repent afterwards.
8. Does your mind go somewhere else while engaged in some task ?
9. Do you remain perturbed with the fear of coming misfortunes ?
10. Do you feel extremely zealous at the progress of your colleagues ?
11. By observing that others are suffering, do you internally feel happy ?
12. Do you sometimes get too irritated to find yourself over burdened ?
13. Do you think yourself unsafe ?
14. Do you sometimes think yourself insulted or a degraded person ?
15. Do you hate or have elergy with so many things ?
16. Are your interests and desires get changed quite soon ?
17. Do you feel that there is no body in this world to show genuine sympathy for you ?
18. Getting upset, do you remain aware what is troubling you ?
19. Don't you realise any difficulty to express what is felt by you at a particular time ?
20. Do you think that you are very much familiar with your goodness and evils ?
21. Do you feel any hesitation or fear to, express or doing a thing in a noble way or inventing something new with your own attempts ?

Sr. No.	STATEMENT
22.	Do you think that you can't do anything in your life ?
23.	Do you know well what makes you happy or sad ?
24.	Do you think that you can very well meet any challenge coming in your life ?
25.	Are you sure that you can easily win others heart ?

26.	Do you like to settle issues with the persons instantly who speaks ill of you ?
27.	Do you soon becomes normal after facing some adversaries in your life ?
28.	Do you feel that you are exercising a lot of control over the things in your life ?
29.	Are you able to take timely proper decisions inspite of so many contradictory desires creeping in your mind ?
30.	Do you usually depends upon the guidance or help from others in solving your own problems ?
31.	Do you execute your all tasks promptly and with full dedications ?
32.	Do you often loose your patience and nerves by getting afraid of the failures ?
33.	Do you feel perturbed for a long on being insulted by somebody else ?
34.	Do you remain uneasy on account of your intention to take revenge on others ?
35.	Are you never satisfied with your work and remain worried for its further improvement ?
36.	Do you think that other people or circumstances are more responsible for your mistakes and improper habits ?
37.	Do you think that you can't do anything properly ?

Sr. No.	STATEMENT
38.	Do you often feel ashamed of your looks and behaviour ?
39.	Do you remain much anxious and agitated until you get your desired object ?
40.	Do you take too much time to learn a new technique by leaving the old ones ?
41.	Do you finish what you set out to do ?
42.	Whether being observed or not, do you stand for fulfilling your responsibilities properly ?
43.	Do you think that you must do something unique than others ?
44.	Do you agree that all of us should pick up the most challenging goals of our life ?
45.	Do you feel extremely bad by listening about your mistakes and weaknesses from others ?
46.	Do you sometimes loose your self-confidence in the moments of despair ?
47.	Whenever confronted with some tedious problem, do you always run after seeking others help ?
48.	Whenever you take a task in your hand, there goes something wrong resulting in the non-realization of your goal ?
49.	Whenever you get a task spoiled, you begin to curse yourself ?
50.	Do you not take any new assignment, unless inspired or forced by someone ?

PART III

51.	Do you think that people nearer to you are fully trust worthy ?
52.	Do others feel that you do not get perturbed even in the hard circumstances ?
53.	Do you know or try to know the type of relationship maintained by the people among themselves in your neighbourhood and friend circle ?

Sr. No.	STATEMENT
54.	Do you have an intuition that one of your friend is in trouble ?
55.	Do you take no time in realising that the other person is befooling you ?
56.	Do you realise soon that the person talking to you is a wolf in lamb's clothing ?
57.	Do you agree that, whatever so it may be, we should not get ourselves involved in other's affairs ?
58.	Do you have full trust in your friend/friends that they will stand by you at the moments of difficulties ?
59.	Do you realise soon that one of your friends or relatives in annoyed with you for some reasons ?
60.	Do you know well that what type of utterances and activities make your friends or relatives feel good or bad ?
61.	Can you say for yourself that you are capable of peeping into the hearts of others by reading their faces ?
62.	Do you say with confidence that you are well aware of the goodness and evils of your intimate friends or relatives ?
63.	Do you know well what is expected from you by your friends or members of the family ?
64.	Do you know well about the liking and dislikings of your nearest friends ?
65.	Do you realize that you are considered trustworthy and responsible by the people ?
66.	Do you try to place the needs and interests of others over your own ?
67.	Do you try to think before saying or doing something about its impact over others ?
68.	Do you give more importance to the maintenance of relationship with others irrespective of the losses or gains incurred in doing so ?
69.	Do you get perturbed by the thought that others are observing you or your actions ?

Sr. No.	STATEMENT
70.	Do you really often realise that who are jealous of your progress ?
71.	Can you tell properly who are your true friends or well wishers ?
72.	While observing people laughing or talking, do you feel that they are laughing at or talking ill of you ?
73.	Do you think that you are liked by the people on account of your good behaviour ?
74.	On falling ill, if one of your colleague enquires about your health, are you able to recognize whether he is showing a genuine sympathy or just pretending ?
75.	Do your friends or relatives expect from you the needed help and guidance at the time of their difficult hours ?

PART IV

76.	Do you easily make friendship or acquaintence with others ?
77.	Do you think that it is not proper to trust anybody in this world ?
78.	Do you not like even to talk to the people who differ with you in opinions ?
79.	Do you easily get sympathy or help from others ?
80.	Do you feel happy in helping others in their difficult moments ?
81.	Do you take responsibility of getting people introduced with one another on some gathering or auspicious occasion ?
82.	Do you often try to provide leadership to some social or group work ?
83.	Do the members of the community of society have reservation in coming closer to you by considering you too much different from them ?
84.	Do you try to listen properly and pay due respect to the people or colleagues whenever they happen to meet you ?

Sr. No.	STATEMENT
85.	Do you think that other people or your colleagues unnecessarily keep over watch or vigilance on your activities ?
86.	Do you often have quarrels with your colleagues or other people ?
87.	If one of your colleagues commits a mistake, do you begin to criticise him before others ?
88.	Do you feel happy in congratulating others for their accomplishments ?
89.	Do you think instantly to help the person as soon as you hear about his problem ?
90.	Do you remain prepared for helping others irrespective of having ideological differences with them ?
91.	Can't you say "I love you" inspite of falling in love with him/her ?
92.	Do you think that it is better to keep distance or remaining emotionally in different with the strangers ?
93.	Do you enjoy laughing at or taunting others ?
94.	Instead of expressing your desire or interest by yourself do you think that the people by themselves will take care of it ?
95.	Do you think that it is your duty to inform your colleagues and relatives with some sad happenings irrespective of its consequences ?
96.	Do you try to ease tension by talking in lighter veins even in the serious moments of a task accomplishment ?
97.	Do you agree that it is good to say a spade a spade in conversation irrespective of its being taken in a good or bad taste by the people ?
98.	Would you like to avoid visiting your friend when he is sad over the demise of a relative of him ?
99.	Do the people relish much to work along with you on some project or to listen to your attentively during a group discussion ?
100.	In conversation, do you wish that the people should continuously listen to you instead of making you listened to them ?

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Dr. S. K. Mangal (Rohtak)
Dr. Shubhra Mangal (Noida)

ANSWER SHEET of EII-MM

(English/Hindi Version)

Please fill up the following informations : Date दिनांक ☐☐☐☐☐☐☐☐

कृपया निम्न सूचनायें भरिए–

Name (नाम)_____

Date of Birth (जन्मतिथि) ☐☐☐☐☐☐☐☐

Class (कक्षा)_____

Age (आयु)_____ **Sex (लिंग) : Male (पुरुष)** ☐ **Female (स्त्री)** ☐

School (विद्यालय) _____

Education (शिक्षा)_____

SCORING TABLE (फलांकन तालिका)

Area	I	II	III	IV	Total Score	Overall Interpretation
Score						
Interpretation						

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UG-1, Nirmal Heights, Near Mental Hospital, Agra-202007

★ Check

PART-I				PART-II				PART-III				PART-IV			
Q. No.	ANSWER			Q. No.	ANSWER			Q. No.	ANSWER			Q. No.	ANSWER		
	Always	Some-times	Never		Always	Some-times	Never		Always	Some-times	Never		Always	Some-times	Never
1	☐	☐	☐	26	☐	☐	☐	51	☐	☐	☐	76	☐	☐	☐
2	☐	☐	☐	27	☐	☐	☐	52	☐	☐	☐	77	☐	☐	☐
3	☐	☐	☐	28	☐	☐	☐	53	☐	☐	☐	78	☐	☐	☐
4	☐	☐	☐	29	☐	☐	☐	54	☐	☐	☐	79	☐	☐	☐
5	☐	☐	☐	30	☐	☐	☐	55	☐	☐	☐	80	☐	☐	☐
6	☐	☐	☐	31	☐	☐	☐	56	☐	☐	☐	81	☐	☐	☐
7	☐	☐	☐	32	☐	☐	☐	57	☐	☐	☐	82	☐	☐	☐
8	☐	☐	☐	33	☐	☐	☐	58	☐	☐	☐	83	☐	☐	☐
9	☐	☐	☐	34	☐	☐	☐	59	☐	☐	☐	84	☐	☐	☐
10	☐	☐	☐	35	☐	☐	☐	60	☐	☐	☐	85	☐	☐	☐
11	☐	☐	☐	36	☐	☐	☐	61	☐	☐	☐	86	☐	☐	☐
12	☐	☐	☐	37	☐	☐	☐	62	☐	☐	☐	87	☐	☐	☐
13	☐	☐	☐	38	☐	☐	☐	63	☐	☐	☐	88	☐	☐	☐
14	☐	☐	☐	39	☐	☐	☐	64	☐	☐	☐	89	☐	☐	☐
15	☐	☐	☐	40	☐	☐	☐	65	☐	☐	☐	90	☐	☐	☐
16	☐	☐	☐	41	☐	☐	☐	66	☐	☐	☐	91	☐	☐	☐
17	☐	☐	☐	42	☐	☐	☐	67	☐	☐	☐	92	☐	☐	☐
18	☐	☐	☐	43	☐	☐	☐	68	☐	☐	☐	93	☐	☐	☐
19	☐	☐	☐	44	☐	☐	☐	69	☐	☐	☐	94	☐	☐	☐
20	☐	☐	☐	45	☐	☐	☐	70	☐	☐	☐	95	☐	☐	☐
21	☐	☐	☐	46	☐	☐	☐	71	☐	☐	☐	96	☐	☐	☐
22	☐	☐	☐	47	☐	☐	☐	72	☐	☐	☐	97	☐	☐	☐
23	☐	☐	☐	48	☐	☐	☐	73	☐	☐	☐	98	☐	☐	☐
24	☐	☐	☐	49	☐	☐	☐	74	☐	☐	☐	99	☐	☐	☐
25	☐	☐	☐	50	☐	☐	☐	75	☐	☐	☐	100	☐	☐	☐
TOTAL-I =				TOTAL-II =				TOTAL-III =				TOTAL-IV =			

Check ★

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S. NO.	Name	AGE	SEX	MRD No.	Education	Occupation	Address	Family type	Occupatio of head of the family	Monthly income	Education of head of family	Scores - Occupation Head of the family	Family income	Scores - Education Head	TOTAL SCORES
1	S.S	48	M	1612896	intermediatent	Semi Skilled	Rural	Joint	Shop owner	7,681-10,240	High school diploma	4	6	5	15
2	J.S	33	M	1624282	intermediatent	Farmer	Rural	Joint	Farmer	1,034-3071	High school diploma	5	2	5	12
3	B.S	45	M	1588466	intermediatent	Farmer	Rural	Joint	Farmer	7,681-10,240	High school certificate	5	6	4	15
4	J.S	47	M	1620256	intermediatent	Farmer	Rural	Joint	Farmer	1,034-3071	High school certificate	5	2	4	11
5	D.S	48	M	1617856	10th Grade	Farmer	Rural	Joint	Farmer	7,681-10,240	High school certificate	5	6	4	15
6	M.S	27	M	1615210	intermediatent	Other	Urban	Nuclear	Semi skilled worker	5,120-7,680	Graduate	3	4	6	13
7	K.S	39	M	1367723	intermediatent	Farmer	Urban	Nuclear	Farmer	>20,482	High school certificate	5	12	4	21
8	H.S	30	M	1582713	Graduate	BUSSINESMAN	Urban	Nuclear	bussinesman	5,120-7,680	High school diploma	9	4	5	18
9	S.S	48	M	803620	intermediatent	Farmer	Rural	joint	farmer	7,681-10,240	High school certificate	5	6	4	15
10	A.S	28	M	1613141	intermediatent	Farmer	Rural	Joint	Farmer	7,681-10,240	High school certificate	5	6	4	15
11	M.S	38	M	1623842	intermediatent	farmer	Rural	Joint	Farmer	7,681-10,240	High School Certificate	5	6	4	15
12	J.S	49	M	236933	8th	Farmer	Rural	joint	Farmer	7,681-10,240	Primary School Certificate	5	6	2	13
13	G.S	36	M	167071	intermediatent	Farmer	Urban	Nuclear	Professional	1,034-3071	High school certificate	9	2	4	15
14	M.S	38	M	1614353	Graduate	Other	Urban	Nuclear	Professional	1,034-3071	Graduate	9	2	6	17
15	B.R	40	M	1611400	intermediatent	Semi Skilled	Urban	Nuclear	Semi skilled worker	7,681-10,240	Primary School Certificate	3	6	2	11
16	H.S	59	M	1603117	10th Grade	Other	Urban	Nuclear	Farmer	3,072-5,119	Primary School Certificate	5	3	2	10
17	R.S	37	M	1610368	Post Graduate	Professional	Urban	Nuclear	Clerical	3,072-5,119	High school diploma	7	3	5	15
18	K.S	43	M	75986	intermediatent	Farmer	Rural	Nuclear	Farmer	3,072-5,119	High school certificate	5	3	4	12
19	H.S	43	M	1607846	intermediatent	Farmer	Rural	Nuclear	Farmer	3,072-5,119	Primary school certificate	5	3	2	10
20	J.S	43	M	1415216	intermediatent	Farmer	Rural	Joint	Farmer	5,120-7,680	Middle school certificate	5	4	3	12
21	N	34	M	1544298	intermediatent	Unemployed	Urban	Joint	Semi skilled worker	1,034-3071	High school certificate	3	2	4	9
22	M.S	53	M	889969	Graduate	Professional	Urban	Nuclear	Shop owner	5,120-7,680	Middle school certificate	4	4	3	11
23	S.S	48	M	1614371	Post Graduate	Professional	Urban	Nuclear	Professional	>20,482	Graduate	9	12	6	27
24	S.S	48	M	1642868	Graduate	Shop owner	Urban	Joint	Shop owner	5,120-7,680	High School Diploma	4	4	5	13
25	M.K	43	M	1619735	intermediatent	Clerk	Urban	Nuclear	Semi skilled worker	7,681-10,240	High School Certificate	3	6	4	13
26	R	60	M	1130022	intermediatent	Semi Skilled	Urban	Nuclear	Semi skilled worker	5,120-7,680	High school diploma	3	4	5	12
27	H.S	43	M	1410610	intermediatent	Farmer	Rural	Joint	Farmer	5,120-7,680	Middle school certificate	5	4	3	12
28	D.S	44	M	1214544	10th Grade	Farmer	Rural	Nuclear	Farmer	5,120-7,680	High School Certificate	5	4	4	13
29	A.S	26	M	1666715	Graduate	Professional	Urban	Nuclear	Farmer	>20,482	High school certificate	5	12	4	21
30	V.	33	M	1608984	intermediatent	Other	Urban	Nuclear	Shop owner	7,681-10,240	High school certificate	4	6	4	14
31	S.S	51	M	1544145	Post Graduate	Professional	Urban	Nuclear	Farmer	>20,482	High school diploma	5	12	5	22
32	G.S	44	M	1662571	10th Grade	Farmer	Rural	Nuclear	Farmer	>20,482	High school certificate	5	12	4	21
33	S	27	M	1662022	intermediatent	Shop owner	Urban	Nuclear	Shop owner	5,120-7,680	Middle school certificate	4	4	3	11
34	G.S	34	M	1665970	Graduate	Professional	Urban	Joint	Clerical	5,120-7,680	High school diploma	7	4	5	16
35	S.S	56	M	1299017	intermediatent	Shop owner	Rural	Nuclear	Shop owner	7,681-10,240	High school certificate	4	6	4	14
36	R.K	51	M	1673015	intermediatent	Other	Urban	Nuclear	Semi skilled worker	>20,482	High school certificate	3	12	4	19
37	N.S	44	M	16488	10th Grade	Farmer	Rural	Joint	Farmer	7,681-10,240	Illitrate	5	6	1	12
38	R.S	56	M	1638188	Graduate	Farmer	Rural	Nuclear	Semi skilled worker	5,120-7,680	Graduate	3	4	6	13
39	A	47	M	176696	10th Grade	Semi Skilled	Urban	Joint	Semi skilled worker	7,681-10,240	High school certificate	3	6	4	13
40	V.S	43	M	1675028	intermediatent	Farmer	Rural	Joint	Farmer	7,681-10,240	High school certificate	5	6	4	15

S. NO.	Name	Socio economic Status	Diagnosis	Time since diagnosis	Pharmacological treatment	Pre-EII	PRE- EII-Grade	Pre-SS	pre SS RAW	pre-SS- GRADE categories	Pre-LOC	pre-loc grade	POST-EII
1	S.S	lower middle class(III)	Alcohol Dependence	7 months	Lorazepam,Thiamine,Baclofen,pantoprazole	41	EXTREMELY LOW	73	6.08	HIGH	16	external loc	75
2	J.S	lower middle class(III)	Alcohol Dependence	8months	Lorazepam,Thiamine,Baclofen,pantoprazole	35	EXTREMELY LOW	29	2.42	LOW	12	internal loc	88
3	B.S	lower middle class(III)	Alcohol Dependence	11months	Lorazepam,Thiamine,Baclofen,pantoprazole	46	EXTREMELY LOW	36	3.00	MODERATE	16	external loc	89
4	J.S	lower middle class(III)	Alcohol Dependence	5months	Lorazepam,Thiamine,Baclofen,pantoprazole	72	EXTREMELY LOW	70	5.83	HIGH	10	internal loc	114
5	D.S	lower middle class(III)	Alcohol Dependence	10months	Lorazepam,Thiamine,Baclofen,pantoprazole	55	EXTREMELY LOW	74	6.17	HIGH	7	internal loc	100
6	M.S	lower middle class(III)	Alcohol Dependence	4months	Lorazepam,Thiamine,Baclofen,pantoprazole	89	LOW	56	4.67	MODERATE	16	external loc	129
7	K.S	upper middle class(II)	Alcohol Dependence	4months	Lorazepam,Thiamine,Baclofen,pantoprazole	78	EXTREMELY LOW	52	4.33	MODERATE	11	internal loc	109
8	H.S	upper middle class(II)	Alcohol Dependence	6months	Lorazepam,Thiamine,Baclofen,pantoprazole	78	EXTREMELY LOW	63	5.25	HIGH	9	internal loc	155
9	S.S	lower middle class(III)	Alcohol Dependence	9months	Lorazepam,Thiamine,Baclofen,pantoprazole	94	LOW	53	4.42	MODERATE	11	internal loc	172
10	A.S	lower middle class(III)	Alcohol Dependence	3months	Lorazepam,Thiamine,Baclofen,pantoprazole	56	EXTREMELY LOW	56	4.67	MODERATE	13	external loc	89
11	M.S	lower middle class(III)	Alcohol Dependence	6months	Lorazepam,Thiamine,Baclofen,pantoprazole	78	EXTREMELY LOW	70	5.83	HIGH	9	internal loc	112
12	J.S	lower middle class(III)	Alcohol Dependence	2months	Lorazepam,Thiamine,Baclofen,pantoprazole	72	EXTREMELY LOW	68	5.67	HIGH	0	internal loc	100
13	G.S	lower middle class(III)	Alcohol Dependence	9months	Lorazepam,Thiamine,Baclofen,pantoprazole	96	LOW	66	5.50	HIGH	12	internal loc	112
14	M.S	upper middle class(II)	Alcohol Dependence	11months	Lorazepam,Thiamine,Baclofen,pantoprazole	44	EXTREMELY LOW	39	3.25	MODERATE	8	internal loc	80
15	B.R	lower middle class(III)	Alcohol Dependence	3months	Lorazepam,Thiamine,Baclofen,pantoprazole	65	EXTREMELY LOW	68	5.67	HIGH	19	external loc	96
16	H.S	upper lower class(IV)	Alcohol Dependence	7months	Lorazepam,Thiamine,Baclofen,pantoprazole	94	LOW	57	4.75	MODERATE	15	external loc	115
17	R.S	lower middle class(III)	Alcohol Dependence	8months	Lorazepam,Thiamine,Baclofen,pantoprazole	78	EXTREMELY LOW	66	5.50	HIGH	11	internal loc	88
18	K.S	lower middle class(III)	Alcohol Dependence	6months	Lorazepam,Thiamine,Baclofen,pantoprazole	61	EXTREMELY LOW	63	5.25	HIGH	16	external loc	96
19	H.S	upper lower class(IV)	Alcohol Dependence	5months	Lorazepam,Thiamine,Baclofen,pantoprazole	84	EXTREMELY LOW	30	2.50	LOW	10	internal loc	119
20	J.S	lower middle class(III)	Alcohol Dependence	4months	Lorazepam,Thiamine,Baclofen,pantoprazole	104	LOW	33	2.75	LOW	12	internal loc	166
21	N	upper lower class(IV)	Alcohol Dependence	3months	Lorazepam,Thiamine,Baclofen,pantoprazole	104	LOW	70	5.83	HIGH	14	external loc	155
22	M.S	lower middle class(III)	Alcohol Dependence	7months	Lorazepam,Thiamine,Baclofen,pantoprazole	90	LOW	60	5.00	MODERATE	9	internal loc	100
23	S.S	UPPER CLASS (1)	Alcohol Dependence	4months	Lorazepam,Thiamine,Baclofen,pantoprazole	97	LOW	38	3.17	MODERATE	13	external loc	100
24	S.S	lower middle class(III)	Alcohol Dependence	5months	Lorazepam,Thiamine,Baclofen,pantoprazole	78	EXTREMELY LOW	32	2.67	LOW	16	external loc	88
25	M.K	lower middle class(III)	Alcohol Dependence	2months	Lorazepam,Thiamine,Baclofen,pantoprazole	72	EXTREMELY LOW	38	3.17	MODERATE	13	external loc	92
26	R	lower middle class(III)	Alcohol Dependence	8months	Lorazepam,Thiamine,Baclofen,pantoprazole	95	LOW	62	5.17	HIGH	14	external loc	120
27	H.S	lower middle class(III)	Alcohol Dependence	9months	Lorazepam,Thiamine,Baclofen,pantoprazole	93	LOW	62	5.17	HIGH	11	internal loc	118
28	D.S	lower middle class(III)	Alcohol Dependence	8months	Lorazepam,Thiamine,Baclofen,pantoprazole	98	LOW	57	4.75	MODERATE	16	external loc	106
29	A.S	upper middle class(II)	Alcohol Dependence	7months	Lorazepam,Thiamine,Baclofen,pantoprazole	99	LOW	68	5.67	HIGH	10	internal loc	125
30	V.	lower middle class(III)	Alcohol Dependence	6months	Lorazepam,Thiamine,Baclofen,pantoprazole	90	LOW	51	4.25	MODERATE	13	external loc	122
31	S.S	upper middle class(II)	Alcohol Dependence	11months	Lorazepam,Thiamine,Baclofen,pantoprazole	67	EXTREMELY LOW	39	3.25	MODERATE	7	internal loc	138
32	G.S	upper middle class(II)	Alcohol Dependence	2months	Lorazepam,Thiamine,Baclofen,pantoprazole	73	EXTREMELY LOW	32	2.67	LOW	14	external loc	118
33	S	lower middle class(III)	Alcohol Dependence	3months	Lorazepam,Thiamine,Baclofen,pantoprazole	98	LOW	46	3.83	MODERATE	13	external loc	97
34	G.S	upper middle class(II)	Alcohol Dependence	11months	Lorazepam,Thiamine,Baclofen,pantoprazole	98	LOW	45	3.75	MODERATE	10	internal loc	109
35	S.S	lower middle class(III)	Alcohol Dependence	11months	Lorazepam,Thiamine,Baclofen,pantoprazole	75	EXTREMELY LOW	49	4.08	MODERATE	11	internal loc	86
36	R.K	upper middle class(II)	Alcohol Dependence	10months	Lorazepam,Thiamine,Baclofen,pantoprazole	47	EXTREMELY LOW	34	2.83	LOW	12	internal loc	58
37	N.S	lower middle class(III)	Alcohol Dependence	10months	Lorazepam,Thiamine,Baclofen,pantoprazole	114	BELOW AVERAGE	35	2.92	LOW	14	external loc	135
38	R.S	lower middle class(III)	Alcohol Dependence	10months	Lorazepam,Thiamine,Baclofen,pantoprazole	101	LOW	52	4.33	MODERATE	14	external loc	112
39	A	lower middle class(III)	Alcohol Dependence	2months	Lorazepam,Thiamine,Baclofen,pantoprazole	79	EXTREMELY LOW	32	2.67	LOW	14	external loc	85
40	V.S	lower middle class(III)	Alcohol Dependence	7months	Lorazepam,Thiamine,Baclofen,pantoprazole	98	LOW	37	3.08	MODERATE	8	internal loc	106

S. NO.	Name	POST-EII-GRADE	Post-SS	POST-ss RAW	POST-SS GRADE	Post-LOC	POST LOC- GARDE	Follow- up EII	FOLLOW-UP EII GRADE	Follow Up-SS	Follows.s Raw	FOLLOW SS= GRADE	Follow Up - LOC	FOLLOW UP LOC GRADE
1	S.S	EXTREMELY LOW	73	6.08	HIGH	12	internal	82	EXTREMELY LOW	76	6.33	HIGH	12	Internal
2	J.S	EXTREMELY LOW	35	2.92	LOW	10	internal	89	LOW	40	3.33	MODERATE	6	Internal
3	B.S	LOW	46	3.83	MODERATE	9	internal	89	LOW	42	3.50	MODERATE	8	Internal
4	J.S	BELOW AVERAGE	79	6.58	HIGH	10	internal	112	BELOW AVERAGE	82	6.83	HIGH	12	Internal
5	D.S	LOW	82	6.83	HIGH	10	internal	102	LOW	80	6.67	HIGH	13	external
6	M.S	AVERAGE	66	5.50	HIGH	13	external	128	AVERAGE	68	5.67	HIGH	15	external
7	K.S	BELOW AVERAGE	68	5.67	HIGH	12	internal	100	LOW	62	5.17	HIGH	11	Internal
8	H.S	AVERAGE	63	5.25	HIGH	11	internal	132	AVERAGE	70	5.83	HIGH	15	external
9	S.S	AVERAGE	77	6.42	HIGH	10	internal	160	ABOVE AVERAGE	68	5.67	HIGH	19	external
10	A.S	LOW	78	6.50	HIGH	10	internal	92	LOW	77	6.42	HIGH	10	Internal
11	M.S	BELOW AVERAGE	72	6.00	HIGH	9	internal	100	LOW	79	6.58	HIGH	6	Internal
12	J.S	LOW	68	5.67	HIGH	3	internal	115	BELOW AVERAGE	60	5.00	MODERATE	6	Internal
13	G.S	BELOW AVERAGE	68	5.67	HIGH	13	external	102	LOW	59	4.92	MODERATE	11	Internal
14	M.S	EXTREMELY LOW	47	3.92	MODERATE	5	internal	83	EXTREMELY LOW	55	4.58	MODERATE	9	Internal
15	B.R	LOW	66	5.50	HIGH	12	internal	100	LOW	70	5.83	HIGH	10	Internal
16	H.S	BELOW AVERAGE	77	6.42	HIGH	9	internal	119	BELOW AVERAGE	82	6.83	HIGH	8	Internal
17	R.S	EXTREMELY LOW	72	6.00	HIGH	9	internal	100	LOW	78	6.50	HIGH	9	Internal
18	K.S	LOW	79	6.58	HIGH	12	internal	99	LOW	80	6.67	HIGH	15	external
19	H.S	BELOW AVERAGE	55	4.58	MODERATE	6	internal	122	BELOW AVERAGE	56	4.67	MODERATE	4	Internal
20	J.S	AVERAGE	44	3.67	MODERATE	8	internal	170	HIGH	48	4.00	MODERATE	9	Internal
21	N	AVERAGE	76	6.33	HIGH	12	internal	145	AVERAGE	79	6.58	HIGH	11	Internal
22	M.S	LOW	72	6.00	HIGH	12	internal	115	BELOW AVERAGE	80	6.67	HIGH	8	Internal
23	S.S	LOW	52	4.33	MODERATE	11	internal	120	BELOW AVERAGE	50	4.17	MODERATE	8	Internal
24	S.S	EXTREMELY LOW	44	3.67	MODERATE	10	internal	82	EXTREMELY LOW	58	4.83	MODERATE	9	Internal
25	M.K	LOW	62	5.17	HIGH	9	internal	115	BELOW AVERAGE	65	5.42	HIGH	5	Internal
26	R	BELOW AVERAGE	61	5.08	MODERATE	8	internal	129	AVERAGE	60	5.00	MODERATE	10	Internal
27	H.S	BELOW AVERAGE	68	5.67	HIGH	11	internal	115	BELOW AVERAGE	72	6.00	HIGH	12	Internal
28	D.S	LOW	80	6.67	HIGH	13	external	109	BELOW AVERAGE	80	6.67	HIGH	9	Internal
29	A.S	BELOW AVERAGE	73	6.08	HIGH	11	internal	120	BELOW AVERAGE	73	6.08	HIGH	8	Internal
30	V.	BELOW AVERAGE	80	6.67	HIGH	12	internal	125	BELOW AVERAGE	55	4.58	MODERATE	15	external
31	S.S	AVERAGE	57	4.75	MODERATE	9	internal	145	AVERAGE	42	3.50	MODERATE	5	Internal
32	G.S	BELOW AVERAGE	48	4.00	MODERATE	15	external	105	LOW	50	4.17	MODERATE	10	Internal
33	S	LOW	68	5.67	HIGH	8	internal	100	LOW	55	4.58	MODERATE	5	Internal
34	G.S	BELOW AVERAGE	55	4.58	MODERATE	12	internal	123	BELOW AVERAGE	82	6.83	HIGH	15	external
35	S.S	EXTREMELY LOW	52	4.33	MODERATE	13	external	100	LOW	60	5.00	MODERATE	6	Internal
36	R.K	EXTREMELY LOW	49	4.08	MODERATE	9	internal	70	EXTREMELY LOW	50	4.17	MODERATE	13	external
37	N.S	AVERAGE	52	4.33	MODERATE	6	internal	136	AVERAGE	55	4.58	MODERATE	7	Internal
38	R.S	BELOW AVERAGE	75	6.25	HIGH	5	internal	115	BELOW AVERAGE	75	6.25	HIGH	8	Internal
39	A	EXTREMELY LOW	55	4.58	MODERATE	7	internal	90	LOW	50	4.17	MODERATE	8	Internal
40	V.S	LOW	50	4.17	MODERATE	8	internal	108	BELOW AVERAGE	49	4.08	MODERATE	9	Internal

Baba Farid University
of Health Sciences
Sadiq Road
Faridkot-151 203 (Pb). INDIA.
Phone : 01639-256232,256236
Tele/Fax : 01639-256235
Email – thesisbfuhs@gmail.com

No. BFUHS/2K24p-TH/ 10776 Date 22/4/24

The Principal,
Dayanand Medical College,
Ludhiana

Subject: Approval of Plan of Thesis.

This is to inform you that the Faculty of Medical Sciences in its meeting held on 22.01.2024 has approved the plan of thesis of **Ms. Deepika Saini**, a student of your college for **M.Phil. (Clinical Psychology)** along with the names of Supervisor/Co-Supervisor as under :-

Topic Plan of Thesis
Effect of cbt on locus of control,emotional telligence,and perceived social support in patient with substance use (alcohol)

Supervisor
Dr.Bholeshwar Prasad Mishra
Prof. & Head
Dept. of Clinical Psychology

Co-Supervisor
1. Dr. Pankaj Kumar
Assoc. Professor
Dept. of Psychiatry
2. Dr. Palak Upadhyay
Assoc. Professor
Dept. of Clinical Psychology

The student has to submit the three copies of thesis (along with PDF format) , to the Controller of Examinations, BFUHS, Faridkot, at least six months before the commencement of theory examination, if he/she is otherwise eligible to take the examination. He /She must directed to attach a photocopy of this letter with the forwarding letter while submitting thesis to the University along with the letter of approval of University for change of supervisor/Co-Supervisor, change of topic,(if any).

Controller of Examinations

Note :

1. *If any discrepancy found regarding topic of thesis or Supervisor/Co-Supervisor, inform undersigned within one month after issue of this letter.*

EFFECT OF CBT ON LOCUS OF CONTROL, EMOTIONAL INTELLIGENCE, AND PERCEIVED SOCIAL SUPPORT IN PATIENT WITH SUBSTANCE USE (ALCOHOL)

DISSERTATION PROPOSAL

FOR APPROVAL OF SUBJECT OF DISSERTATION TO BE SUBMITTED

IN PARTIAL FULFILMENT OF THE REQUIREMENTS

FOR THE DEGREE OF

M. PHIL

IN

CLINICAL PSYCHOLOGY

OF THE

BABA FARID UNIVERSITY OF HEALTH SCIENCES

FARIDKOT

MARCH, 2023

MS. DEEPIKA SAINI

DEPARTMENT OF CLINICAL PSYCHOLOGY
DAYANAND MEDICAL COLLEGE AND HOSPITAL
LUDHIANA

ABSTRACT OF PLAN OF DISSERTATION

Title	EFFECT OF CBT ON LOCUS OF CONTROL, EMOTIONAL INTELLIGENCE, AND PERCEIVED SOCIAL SUPPORT IN PATIENT WITH SUBSTANCE USE (ALCOHOL)
For the degree of	M. Phil Clinical Psychology
Name of the candidate	Ms. Deepika Saini
Supervisor	Dr. Bholeshwar Prasad Mishra, Professor & Head, Department of Clinical Psychology, DMCH, Ludhiana
Co-supervisors	Dr. Pankaj kumar, Associate Professor, Department of Psychiatry, DMCH, Ludhiana Palak Upadhyay, Assistant Professor, Department of Clinical Psychology, DMCH, Ludhiana
Institution	Dayanand Medical College & Hospital, Ludhiana
University	Baba Farid University of Health Sciences, Faridkot

Introduction: Substance use disorder is a health condition involving compulsive substance use. Substance use can disrupt emotional balance of individuals and affect emergence of mood disorders. Evidence suggests decrease in perceived social support results in an increased consumption of substance along with an external locus of control which further contributes to relapse. CBT is considered the gold standard in substance use treatment which promotes EQ by management of emotions and increment in coping skills resulting in an increased perception of control. The present study aims at identifying the effectiveness of CBT on the relationship between perception of control, EQ and perceived social support.

Aim of Study: 1)To study the pre –post effect of Cognitive Behavioral Therapy (CBT) on locus of control in patients with substance use disorder(alcohol).(2)To study the pre -post effect of Cognitive Behavioral Therapy (CBT) on Emotional Intelligence in patients with substance use disorder (alcohol).(3)To study the pre –post effect of Cognitive Behavioral Therapy (CBT) On Perceived Social Support in patient with substance use disorder(alcohol).

Materials & methods: Study will be conducted on 40 patients diagnosed with alcohol use, admitted in psychiatry ward or visiting psychiatry OPD & IPD. They will fill Rotter's Locus of Control Scale, Multidimensional Scale of Perceived Social Support, Emotional intelligence Inventory (EQ- I) pre and post intervention.

Clinical Significance: Effect Of CBT On Locus Of Control, Emotional Intelligence, And Perceived Social Support In Patient With Substance Use (Alcohol)

Keywords: Locus Of Control, Emotional Intelligence, Perceived Social Support ,cognitive behavioural therapy.

(Signature)	(Signature)	(Signature)	(Signature)	(Signature)
Candidate	Co-supervisor	Co-supervisor	Supervisor	Principal

CERTIFICATE OF FACILITIES AVAILABLE

This is to certify that the facilities for work on the subject of dissertation titled **"EFFECT OF CBT ON LOCUS OF CONTROL, EMOTIONAL INTELLIGENCE, AND PERCEIVED SOCIAL SUPPORT IN PATIENT WITH SUBSTANCE USE (ALCOHOL)"** exist in the Department of Clinical Psychology, DMC&H, Ludhiana and will be provided to the candidate. We will see that the data being included in the dissertation is genuine and is collected by the candidate herself under our supervision and guidance.

Supervisor

Dr. Bholeshwar Prasad Mishra
Professor & Head
Department of Clinical Psychology
DMCH, Ludhiana

Co-Supervisors

Dr. Pankaj Kumar
Associate Professor
Department of Psychiatry
DMCH,Ludhiana

Palak Upadhyay
Assistant Professor
Department of Clinical Psychology
DMCH, Ludhiana

Head of the Department

Dr. Bholeshwar Prasad Mishra
Professor & Head
Clinical Psychology Department
DMCH

Place: _____

Date: _____

APPROVAL PROFORMA

BY RESEARCH & ETHICAL COMMITTEE
DAYANAND MEDICAL COLLEGE & HOSPITAL, LUDHIANA

Name of candidate	Ms. Deepika Saini
Department	Clinical Psychology
Topic of Dissertation	EFFECT OF CBT ON LOCUS OF CONTROL, EMOTIONAL INTELLIGENCE, AND PERCEIVED SOCIAL SUPPORT IN PATIENT WITH SUBSTANCE USE(ALCOHOL)
Likely date of appearing in PG examination	August, 2024
Date of enrollment	16.08.2022
Name of Head of Department	Dr. Bholeshwar Prasad Mishra
1) Supervisor **2) Co-Supervisor(s)**	Dr. Bholeshwar Prasad Mishra Dr. Pankaj Kumar Palak Upadhyay
Signature of Members of Research Committee with Stamp	**Signature of Members of Ethics Committee with Stamp**
Dr. Harpreet Kaur (Professor & Head, Pathology)	Adv. Ankur Ghai (Legal Expert)
Dr. Jaspal Singh (Professor & Head, Surgery)	Dr. Suvir Singh (Associate Professor, Haematology)
Dr. Dinesh Gupta (Professor & Head, Medicine)	Dr. Ramit Mahajan (Professor, Gastroenterology)
Dr. Sandeep Kaushal (Dean Academics & Professor & Head, Pharmacology)	Dr. Ashvind Bawa (Professor, Surgery)
Dr. Gurpreet S Wander (Vice Principal)	Dr. Sandeep Kaushal (Professor & Head, Pharmacology)
	Dr. Gurpreet S Wander (Professor, Cardiology)
	Dr. Rajesh Mahajan (Secretary, Ethics Committee Professor, Medicine)

Approved: Yes / No

Dr. Sandeep Puri
Chairperson
Research Committee

Approved: Yes / ~~No~~

Prof. Arvind Malhotra
Chairperson
Ethics Committee

BABA FARID UNIVERSITY OF HEALTH SCIENCES, FARIDKOT

PROFORMA FOR REGISTRATION OF SUBJECT FOR DISSERTATION

1	NAME OF THE CANDIDATE AND ADDRESS	Ms. DEEPIKA SAINI V.P.O MARARA, DISTRICT GURDASPUR , PUNJAB 141001
2	NAME OF THE INSTITUTE	DAYANAND MEDICAL COLLEGE AND HOSPITAL, LUDHIANA
3	COURSE OF STUDY AND SUBJECT	M PHIL CLINICAL PSYCHOLOGY
4	DATE OF ADMISSION OF COURSE	16.08.2022
5	TITLE OF THE TOPIC	EFFECT OF CBT ON LOCUS OF CONTROL, EMOTIONAL INTELLIGENCE, AND PERCEIVED SOCIAL SUPPORT IN PATIENT WITH SUBSTANCE USE DISORDER (ALCOHOL)

6. BRIEF RESUME OF THE INTENDED WORK

6.1 NEED FOR THE STUDY

Substance use disorder is a health condition involving compulsive substance use. It develops when substance use interferes with the ability to function day to day.

According (DSM-5)[1] is a chronic and complex disorder involving the continued use of drugs or alcohol (substances) despite significant substance-related problems. Substance misuse and addiction can affect anyone.

Substance use disorders are a major public health concern in Punjab reports estimate of prevalence of substance use disorders in Punjab, conducted as part of National Mental Health Survey (2019)[2], India. 2895 individuals from 719 households of 60 clusters (from 4 districts of Punjab) were interviewed. The prevalence of alcohol and other substance use disorders was 7.9 and 2.48 %, The prevalence of tobacco dependence was 5.5 %; The prevalence was highest in the age group 30-39 years, The prevalence of alcohol and other substance use disorders was much higher in Punjab as compared to other States where survey was done. Tobacco dependence was lowest in Punjab.

Locus Of Control is the degree to which people believe that they, as opposed to external forces (beyond their control), have control over the outcome of events in their lives. The concept was developed by Julian B. Rotter in 1954[3], since become an aspect of personality studies. A person's "locus" is conceptualized as internal (a belief that one can control one's own life) or external (a belief that life is controlled by outside factors which the person cannot influence, or that chance or fate controls their lives).

Emotions are conscious mental reactions (such as anger or fear) subjectively experienced as strong feelings usually directed toward a

specific object and typically accompanied by physiological and behavioral changes in the body. (APA.Emotions 2022)[4]

Perceived Social Support has been defined in various ways (Schwarzer, Knoll, & Rieckmann, 2004).[5] It refers to the function and quality of social relationships, such as perceived availability of help or support actually received. Social support occurs through an interactive process and can be related to altruism, a sense of obligation, and the perception of reciprocity (Schwarzer & Leppin, 1991).[6] Number of studies have been conducted indicating the CBT is beneficial therapy option that can be utilized for various substance use disorder. CBT works towards identify trigger, helps to cope with craving, identify/changing negative automatic thoughts through cognitive restructuring, enhancing problem solving skills. CBT also reduced the risk of relapse.

Although research has been done in this area, there is a lack of the same in the Indian community. CBT is the gold standard intervention for patients with substance use disorders, but there has been very little investigation of undertaken on the current variables in the patients with substance use . The goal of the current study is to fill a gap in the literature by examining how CBT affects patients with substance use disorder specifically in alcohol use in terms of the locus of control, perceived social support and emotional intelligence of the patient.

INTERVENTION TO BE USED IN THE STUDY

Since the middle of the 1980s, CBT has been widely promoted for the treatment of substance use. According to this therapeutic approach, people who use substance have inadequate coping mechanisms, apply conditional and traditional learning processes which makes them more susceptible to addiction. CBT should be applied in a collaborative manner, with a warm manner, and based on a treatment relationship. In first session The definitions of locus of control, perceived social support, and emotional intelligence would then be introduced. Next two sessions ABC

concept and CBT principle, in fourth session raise awareness of the value of personal goals. In next two sessions assist clients in building a new belief while also enabling them to comprehend how the ABC notion relates to their existing beliefs. In last two sessions Identifying Low self Esteem and strategies to deal with Cravings . In last session will provide them tools to avoid relapse and stay on the path of recovery.

6.2 REVIEW OF LITERATURE

Richter, Brown,1991[7],conducted a study to examines social support characteristics and self-esteem in relation to outcome following adolescent chemical dependency treatment. Adolescents and their parents completed self-report questionnaires and a research interview during treatment and at 6 and12-months post-treatment. 2 types of outcomes were assessed at follow-up: (1) alcohol and drug use, and (2) functioning in major life domains. Results indicate that the quality of social resources reported during treatment was related to alcohol and drug-use status post-treatment, with abstainers reporting more non-using supports than teens who returned to heavy drug use. Self-esteem and the degree of satisfaction with social support during treatment were negatively correlated with the number of major life problems during the 6 months following discharge. Altogether, inpatient measures of self-esteem, number of high-quality supports, and social support satisfaction accounted for 16% of the variance in 6-month substance use outcome and 25% of the variance in psychosocial functioning 6 months post-treatment. 6 months social support and self-esteem measures were similarly related to 1-year outcome.

Sandoz, MA (1992)[8] conducted a study on a group of recovering alcoholics in A.A. The total 52 adults (35 males-17 females) is compared with a group of non-problem drinkers. Measures of locus of control, emotional maturity and intimacy with parents are used as points of comparison. The A.A. group differs significantly with the other group in its greater belief in an external locus of control, in its greater emotional dependency and its lower intimacy level with parents.

Reel, McCrady (2010)[9] This study tested an integrated relapse model drawing hypotheses from both interpersonal and intra-individual relapse models. It was hypothesized that the relationships b/w alcohol-specific social support and drinking outcomes would be partially mediated by

motivation. Total 158 women with alcohol use disorders, 1 trial compared standard individual cognitive behavioural therapy (CBT) for alcohol use disorders with female-specific CBT for alcohol use disorders; the other compared alcohol behavioural couple therapy with blended individual CBT and alcohol behavioural couple therapy. Measures included the Important People Interview to measure social-support variables. This study offers preliminary evidence that motivation is one mechanism by which abstinence-specific social support affects treatment outcome.

Masjedi, Taghavizadeh,(2015)[10] carried out a research with the aim of examining the effectiveness of CBT training on the general health and improve the emotional intelligence of male adolescents ,research is pre-test-post-test experimental design and 2 test and control groups, which were carried out in the 2014-15 academic year. 40 male students and control team (each n = 20). The students were protested via Baron emotional intelligence and GHQ-28. the test group was trained in the CBT for 8 sessions and the control group received no interventions. The findings indicated that the CBT practice is useful in improving emotional intelligence and general health in adolescent male students.

Prakash, Sharma(2015)[11] aim of study is To assess personality disorder (PD), emotional intelligence (EI), and locus of control of alcohol dependent(AD) patients and its comparison with normal controls, 33 AD patients were selected from the De-Addiction Ward of (RINPAS) and 33 matched normal subjects were selected from Ranchi and nearby places. Both the groups were matched on various sociodemographic parameters, that is age, gender, and socioeconomic level. All participants were assessed with MCMI-III, Mangal EI Inventory, and Locus of Control scale. Patients with AD have significantly higher PDs, low EI, and an external orientation on the locus of control. Identification and management of these comorbid conditions are likely to improve the management and outcome of AD.

Hussinl, Salimah Alias, (2015)[12], conducted a study to examine the effectiveness of Brief CBT module on locus of control among drug abusers. The quasi-experimental design with one treatment group [CBT (B)] and 1control group (KW) and 4 measurements (pre, post I, post 2, and post 3) were employed in this study. The sample of 108 drug abusers was chosen using purposive sampling procedure. Samples were then distributed randomly into 2 groups: CBT (B) and control group. Each group consisted of 36 samples. As a whole, this study shows that CBT (B) intervention is able to increase locus of control.

Nikmanesh, Baluchi,2016[13] conduct a study to investigate the role of self-efficacy beliefs and social support on prediction of addiction relapse. The study population included 166 participants (83 participants without and 83 participants with relapse). The variables were measured by general self-efficacy scale and Multidimensional Scale of Perceived Social Support. Based on the findings of the study, it can be concluded that self-efficacy beliefs and social support play effective roles in preventing patients from addiction relapse.

Ghahari, Atefvahid (2018)[14] conducted a study on: Among Drug Addiction Centres of Tehran, with the objective Low emotional intelligence can affect coping strategy of individuals and is one of the risk factors of addiction. these individuals were screened through fulfilling The Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II) in terms of personality disorders. 36 people were selected using random sampling and were placed in two 18-member groups. Experimental group was under cognitive-behavioural techniques for 12 sessions and control group was in waiting list. Both groups were evaluated in baseline, session 6, end of treatment and 3 months follow up. Experimental group has demonstrated significant improvement compared to control group during 4 times measurement in scales including Interpersonal, intrapersonal, general

mood, adaptability and stress tolerance scales CBT approach can affect promotion of emotional intelligence of Cannabis users.

Mahdi Moshki, Mahmoud Panahi-Shahri, (2018)[15] The study aimed to investigate the relationship between treatment motivation, substance use, craving, withdrawal symptoms and health locus of control in addicted patients. Research population this study included all male and female patients referring to the addiction treatment center. sample size was determined as 100 participants. Data collection tools consisted of questionnaires demographic characteristics, treatment motivation, craving, withdrawal symptoms and multidimensional Health Locus of Control. There was significant relationship between treatment motivation with craving, withdrawal symptoms and health locus of control and between treatment motivation with variables of sex, education, occupation and type of substance Considering the role of treatment motivation in reducing the return to drugs and the more willingness to treat and relapse less in people with internal control of control in future plans to address the problem of addiction and pushing addicts to treatment, the relevant variables have paid particular attention.

Zaidia(2020)[16] conducted a study Addiction is a behavioural and psychological disorder that can cause unprecedented social, mental, and physiological effects. A patient's neighbourhood, peers, family members, and spouse, play crucial roles in relapse prevention. The primary objectives of this is analysing the significance of social support in preventing relapse. examine drug abuse and relapse in general, addiction as a psychological issue, benefits of social support in preventing relapse. The review will also provide recommendations for future research in this field, to reduce the prevalence of drug and substance use and relapse, these factors confirm that both digital and physical social support are effective in creating a sense of purpose for drug addicts and reducing feelings of social isolation

Hashemi , Hashemi(2020)[17]conduct a study to examine The people who seem to have less social support And suffer lack of multiple social supports are more likely at risk to drug abuse, This research was an experimental with pre-test post-test design with randomly assigned 30 patients experimental and control groups. present aim at testing the effect of 8, 2- hour sessions of stress management training based on cognitive behavioral techniques. Interventions based on cognitive behavioral approaches, is effective treatment that it can alters behavioral and cognitive factors associated with substance use and be as an efficient model for the prevention of drug abuse and also after treatment.

Reyes, Rossi (2021)[18] conducted a study for Black emerging adults are significantly impacted by substance misuse. Posttraumatic stress disorder (PTSD) is associated with heightened substance misuse among Black emerging adults. limited research has identified protective factors that may influence the strength of the relation between PTSD and substance misuse in this population. Addressing this important limitation, Participants were 182 trauma-exposed Black emerging adults, who completed self-report measures assessing PTSD symptoms, alcohol and drug misuse, and perceived social support. These findings suggest the potential utility of addressing social support in the assessment and treatment of substance misuse in trauma-exposed Black emerging adults.

Shiraz, Ghoochani (2022)[19] The study is aimed to investigate the relationship between resilience, locus of control, and emotional intelligence in opium addicts. A total of 40 male opium addicts were selected by convenience sampling and demographic questionnaires were used in this cross-sectional study, and Pearson's test was used to obtain the correlation coefficient. Addiction treatment centres should evaluate and improve the levels of resilience, emotional intelligence, and type of locus of control in addicts. ages range is 20- 25 years. findings suggest the CBT have effect on locus of control, emotional intelligence and the role of perceived social support in substance use treatment.

Patel, Sharma, 2022[20] conducted a study to examine the relationship of alcohol use pattern with locus of control and impulsivity: A cross-sectional study in hospitalized alcohol use disorder patients in Western India indoor patients in tertiary care hospital, ages 18- 65 years diagnosed as AUD according to DSM-5, after acute detoxification was done. For interview, a sociodemographic sheet, Alcohol Use Disorder Identification Test, Drinking-Related Locus of Control Scale, and Barrett's Impulsiveness Scale 11 scale (Gujarati versions) were used, Total participants consisted of 65% (35–50 years) rural inhabitants. External LOC and impulsivity have a strong association with alcohol use. Patients with high external LOC and more impulsivity had early age of first intake, severe alcohol use, and more duration of alcohol consumption.

6.3 AIMS AND OBJECTIVES OF THE STUDY

- To study the pre –post effect of Cognitive Behavioral Therapy (CBT) on locus of control in patients with substance use disorder(alcohol).
- To study the pre -post effect of Cognitive Behavioral Therapy (CBT) on Emotional Intelligence in patients with substance use disorder (alcohol).
- To study the pre –post effect of Cognitive Behavioral Therapy (CBT) On Perceived Social Support in patient with substance use disorder(alcohol).

7. MATERIALS AND METHODS

7.1 SOURCE OF DATA

Study will be conducted on 40 patients diagnosed with substance use disorder(alcohol), as per ICD 10 criteria admitted in psychiatry ward or visiting de-addiction OPD at Dayanand medical college and hospital, Ludhiana.

METHOD OF COLLECTION:

Study design: pre and post intervention.

Sample size: 40 substances use disorder patients of either gender within age group of 18-60 years.

Sample design: Purposive sampling design will be used. The patients who meet the inclusion criteria will be selected for the study.

INCLUSION CRITERIA

- ICD 10 diagnosis of substance use disorder (alcohol)
- Undergoing pharmacological treatment and in maintenance phase of treatment.
- Age range between 18 and 60 years
- Either gender
- Primary level education
- Time since diagnosis >1 years.
- Patient willing to give informed consent

EXCLUSION CRITERIA

- Patients with any other comorbid psychiatric disorder
- Major neurological disorder or communication disorder

- History of intellectual disability
- History of any other substance use except tobacco.

DESCRIPTION OF THE TOOLS:

1. **SOCIO DEMOGRAPHIC PERFORMA (Kuppuswamy, 2019)** (Sheikh Mohd Saleem 2019)[21]

A semi structured proforma was designed for present study in order to collect detailed clinical history of each participant including information related to following areas:

- Socio demographic details including age , gender, MRD number, education, occupation, income, marital status, family type, socio- economic status
- Duration of illness, type of complication
- Scores of all the test.

2. **Emotional intelligence Inventory**: It was designed by DR. S.K Mangal (Mangal 2015)[22] and has been designed for use with Hindi and English knowing individuals of 16+ years age. It measures major 4 areas or aspects of emotional intelligence namely, intra- personal awareness (own emotions) and inter- personal awareness (others' emotions), intra personal management (own emotions) and inter personal management (others' emotions). It has 100 items, 25 each from the four areas that are answered as yes/no. The score range for the test are follow 170 -187is high, 151- 169 is above average,126 to 150- average ,107-125 is below average, 89-106 is low, below 88 is extremely low.

3. **Rotter's Locus of Control Scale : Developed by** Julian B. Rotter (1966) (Chaudhury et al. 2015)[23] it is widely used in psychological research to investigate internal versus external locus of control. It comprises of 29 statement pairs. For each items, the respondent have to

select the statement they agree with most from option A/B. Score ranges from 0 to 13, with lower scores indicating internal control and higher scores indicating external locus of control.

4. Multidimensional Scale of Perceived Social Support: It is a 12-item instrument which assesses the perceived adequacy of social support from family, friends, and special other person. Items are rated on a 7-point Likert-type scale ranging from 1 (very strongly agree) to 7 (very strongly disagree). Higher score indicates greater perceived social support. (Zimet 2016)[24]

PROCEDURE

Baseline appointment- The participant will first undergo informed consent process, in which the necessary information would be provided to enable the participant to make an informed decision. The participants who provide consent would then be given baseline assessments along with Kuppuswamy's Socio-Economic Status Scale (Saleem, Jan., 202136).[25] Participants would be evaluated on the baseline assessments Emotional Intelligence Inventory, Rotter's Locus of Control Scale and Multidimensional Scale of Perceived Social Support. After the initial assessments all the participants would undergo 8 weekly sessions of CBT of 30 minutes each. Post intervention they would be reassessed on baseline assessments. The scores would than be compared and analysed using appropriate statistics.

Intervention appointment-: The table below depicts the therapy session plan for the study group participants.

Intervention is derived from Cognitive-Behavioral Therapy Book and Behavior Therapy Book;

1.	Baseline assessment	Detailed history, baseline assessments.
2.	Session 1	Psychoeducation on the interplay of emotional intelligence, perceived social support , locus of control on addiction.
3.	Session 2	Introducing the CBT principle and ABC concept of substance use.
4.	Session 3	Identification of triggers will be done, Relaxation exercise will be introduced to help cope with craving.
5.	Session 4	Socratic questioning for regaining locus of control and identifying negative automatic thoughts.
6.	Session 5	Changing negative automatic thoughts through Cognitive Restructuring, Helping patient to understand the reality of addiction and cost involve with it. Homework Assignment will be given.
7.	Session 6	Introducing of adaptive problem-solving skills and conflict resolution strategies.
8.	Session 7	Aassertive skills training and emotional regulation strategies will be introduced, customized plan for using CBT to help reduce the risk of relapse or reach future goals.

9.	Session 8	Follow up and termination; Post intervention assessment

OUTCOME

In this study it will be observed that patient diagnosed with substance use disorder (alcohol) will have internal locus of control, low emotional intelligence and low perceived social support. Use of cognitive behaviour therapy with patient diagnosed with substance use disorder (alcohol) will yield positive results in terms of improving their locus of control, emotional intelligence, and perceived social support. The findings of the present study would add to enrich the existing fund of knowledge. This will have direct and practical implications for therapeutic planning and relapse prevention while treating patients with substance use disorder.

STATISTICAL ANALYSIS

Comparison of pre and post quantitative variables will be done using Paired t-test and Wilcoxon Rank test for independent samples for parametric and non-parametric data respectively. All statistical calculations will be done using (Statistical Package for the Social Science) SPSS 21version (SPSS Inc., Chicago, IL, USA) statistical program for Microsoft Windows.

7.3 DOES THE STUDY REQUIRE ANY INVESTIGATIONS OR INTERVENTIONS TO BE CONDUCTED ON PATIENTS OR OTHER HUMANS OR ANIMALS? IF SO, PLEASE DESCRIBE BRIEFLY.

No

7.4 HAS ETHICAL CLEARENCE BEEN OBTAINED FROM YOUR INSTITUTION IN CASE OF 7.3?

Yes, Attached herewith.

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INFORMED PATIENT CONSENT

Date: _____

I.....D/o, W/o, S/o..... .....am willing to participate in the study **"EFFECT OF CBT ON LOCUS OF CONTROL, EMOTIONAL INTELLIGENCE, AND PERCEIVED SOCIAL SUPPORT IN PATIENT WITH SUBSTANCE USE (ALCOHOL)"** The procedure with its complications has been explained to me in local vernacular language. I have fully understood that no special tests and extra expenditure in any form, merely for the purpose of dissertation is being carried out. I am free to opt out the study any time without assigning any reason.

....

Signature of the Witness Signature of the patient

Name:

Signature of Candidate

Signature of Supervisor

मरीज अनुमति फार्म

तिथि _____

मैं _____ पत्नी/पुत्र/पुत्री _____

निवासी _____

इस शोधकार्य **"EFFECT OF CBT ON LOCUS OF CONTROL, EMOTIONAL INTELLIGENCE, AND PERCEIVED SOCIAL SUPPORT IN PATIENT WITH SUBSTANCE USE (ALCOHOL)"** में भाग लेने के लिए सहमत हूँ। मैं इस शोधकार्य में भाग लेने के लिए अपनी स्वेच्छा से तैयार हूँ। मैं पुष्टि करता/करती हूँ की यह स्वीकृति देने के लिए मुझे कोई आर्थिक प्रलोभन नहीं दिया गया और न ही दबाव डाला गया है। मुझे इस शोधकार्य का उद्देश्य स्पष्ट कर दिया गया है और मुझे यह विश्वास है की यह विज्ञान और मानवता के लाभ के लिए है। मुझे इस शोधकार्य में होने वाले जोखिम के बारे में समझा दिया गया है और मेरी समझ में यह जोखिम बहुत मामुली है।

मैं इस शोधकार्य में भाग लेने के सम्बन्ध में किसी भी समय अपनी अस्वीकृति व्यक्त कर सकता/सकती हूँ और मेरे अस्वीकृति व्यक्त करने का मेरे इलाज पर कोई प्रभाव नहीं पड़ेगा।

_____ _____

गवाह के हस्ताक्षर रोगी के हस्ताक्षर/अंगूठे का निशान

नाम: नाम:

_____

अन्वेषक के हस्ताक्षर

_____

विद्यार्थी के हस्ताक्षर

ਮਰੀਜ਼ ਰਜ਼ਾਮੰਦੀ ਫਾਰਮ

ਮਿਤੀ_____

ਮੈ_____ਪਤਨੀ/ਪੁੱਤਰ/ਪੁੱਤਰੀ_____

ਵਾਸੀ_____ _____

"EFFECT OF CBT ON LOCUS OF CONTROL, EMOTIONAL INTELLIGENCE, AND PERCEIVED SOCIAL SUPPORT IN PATIENT WITH SUBSTANCE USE (ALCOHOL)" ਤੇ ਚਲ ਰਹੀ ਖੋਜ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਲਈ ਰਜ਼ਾਮੰਦ ਹਾਂ ।ਇਸ ਖੋਜ ਕੰਮ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਲਈ ਮੈ ਆਪਣੀ ਮਰਜ਼ੀ ਨਾਲ ਤਿਆਰ ਹਾਂ ।ਮੈ ਇਹ ਦਸਣਾ ਚਾਹੁੰਦਾ ਹਾਂ/ ਚਾਹੁੰਦੀ ਹਾਂ ਕੇ ਇਹ ਰਜ਼ਾਮੰਦੀ ਦੇਣ ਵਾਸਤੇ ਮੈਨੂ ਕਿਸੇ ਵੀ ਤਰਾਂ ਦਾ ਲੋਭ-ਲਾਲਚ ਨਹੀ ਦਿੱਤਾ ਗਿਆ ਅਤੇ ਨਾ ਹੀ ਕੋਈ ਦਬਾ ਪਾਇਆ ਗਿਆ ਹੈ। ਮੈਨੂ ਇਸ ਖੋਜ ਦਾ ਮਨੋਰਥ ਸਮਝਾ ਦਿੱਤਾ ਗਿਆ ਹੈ ਅਤੇ ਮੈਨੂ ਇਹ ਭਰੋਸਾ ਦਵਾਇਆ ਗਿਆ ਹੈ ਕੇ ਇਹ ਖੋਜ ਵਿਗਿਆਨ ਅਤੇ ਮਾਨਵਤਾ ਦੀ ਭਲਾਈ ਲਈ ਹੈ ।ਮੈਨੂ ਇਸ ਖੋਜ ਵਿਚ ਹੋਣ ਵਾਲੇ ਖਤਰੇ ਬਾਰੇ ਸਮਝਾ ਦਿੱਤਾ ਗਿਆ ਹੈ ਅਤੇ ਮੈਨੂ ਇਹ ਯਕੀਨ ਹੈ ਕੇ ਇਹ ਖਤਰਾ ਬਹੁਤ ਮਾਮੂਲੀ ਹੈ ।ਮੈਨੂ ਇਸ ਖੋਜ ਕੰਮ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਦਾ ਢੰਗ – ਤਰੀਕਾ ਸਮਝਾ ਦਿੱਤਾ ਗਿਆ ਹੈ।

ਮੈ ਇਸ ਖੋਜ ਕੰਮ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਬਾਰੇ ਆਪਣੀ ਰਜ਼ਾਮੰਦੀ ਕਿਸੇ ਵੀ ਸਮੇ ਵਾਪਸ ਲੈ ਸਕਦਾ ਹਾਂ/ ਸਕਦੀ ਹਾਂ ਅਤੇ ਮੇਰੀ ਰਜ਼ਾਮੰਦੀ ਵਾਪਸ ਲੈਣ ਦਾ ਮੇਰੇ ਇਲਾਜ ਤੇ ਕੋਈ ਅਸਰ ਨਹੀ ਹੋਵੇਗਾ।

_____ _____

ਗਵਾਹ ਦੇ ਹਸਤਾਖਰ ਮਰੀਜ਼ ਦੇ ਹਸਤਾਖਰ

ਮਿਤੀ_____ _____ਮਿਤੀ

ਪਤਾ _____ ਪਤਾ_____

_____

ਨਿਰੀਖਕ ਦੇ ਹਸਤਾਖਰ

_____

ਸਿਖਿਆਰਥੀ ਦੇ ਹਸਤਾਖਰ